January 1998 Edition

Active Projects Report

Research and Demonstrations in Health Care Financing

Contents

HEALTH CARE FINANCING ADMINISTRATION

U.S. Department of Health and Human Services
Donna E. Shalala, Secretary

Health Care Financing Administration
Nancy-Ann Min DeParle, Administrator

Office of Strategic Planning
Barbara S. Cooper, Director
Thomas A. Gustafson, Deputy Director

This report was produced by:

Systems, Technical and Analytic Resources Group
William D. Saunders, Director
Samuel McNeill, Deputy Director

***Active Projects Report* Production Staff**
Production Coordinator
Sydney P. Galloway
Editor
Debbie Green

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Active Projects Report

Research and Demonstrations in Health Care Financing

January 1998 Edition

Health Care Financing Administration
Office of Strategic Planning

Foreword

As the Federal agency that administers the Medicare, Medicaid and Child Health Insurance Programs, the Health Care Financing Administration (HCFA) directs more than 350 research, demonstration, and evaluation projects to develop and implement new health care payment approaches and financing policies, and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, and others. Many of these projects focus on the relationship of payment, coverage, eligibility and management alternatives under Medicare and Medicaid to program expenditures. HCFA's research also examines the quality of health care, alternative health care delivery systems, innovative financing arrangements and cost containment strategies. In addition, HCFA-sponsored studies assess the impacts of Medicare and Medicaid on beneficiaries' health status, access to services, utilization, and out-of-pocket expenditures. The behavior and economics of health care providers and the overall health care industry also are topics of investigation.

This report is prepared by the Office of Strategic Planning (OSP) to inform customers of HCFA's research. As the planning and research arm of HCFA, OSP coordinates HCFA's research, demonstration, and evaluation activities. OSP conducts research and evaluations and shares responsibility with several other HCFA components the development and implementation of demonstration projects: the Center for Beneficiary Services, the Center for Health Plans and Providers, the Center for Medicaid and State Operations, and the Office of Clinical Standards and Quality. This report provides basic information on HCFA research, demonstration and evaluation projects active from October 1, 1996 through December 31, 1997. Included are intramural projects conducted by HCFA staff and extramural projects conducted by contractors, grantees, and other awardees with HCFA support.

The research and demonstration project summaries are grouped in four general research themes, which reflect HCFA's cross-cutting research priorities:

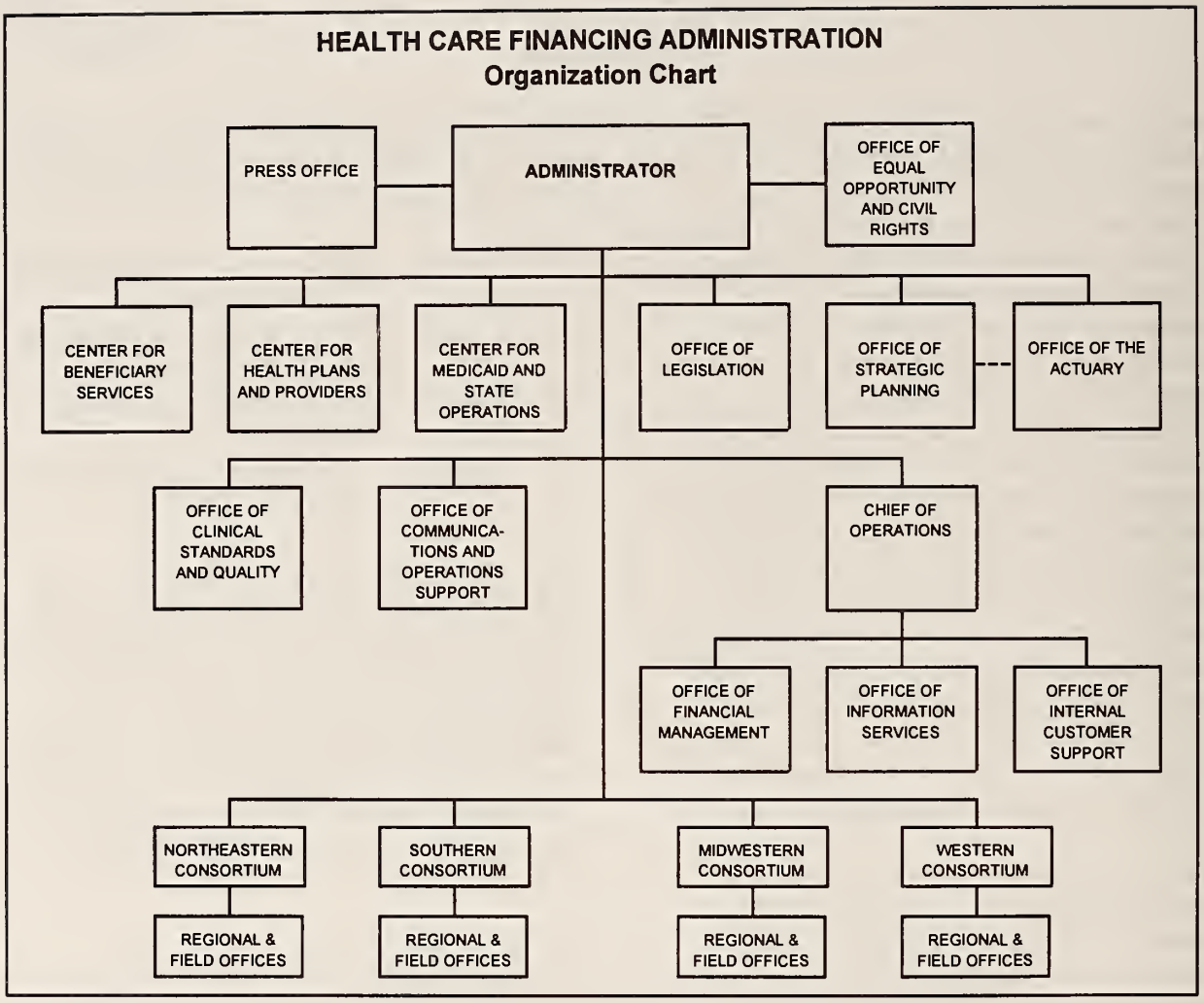
- Theme 1 - Monitoring and Evaluating Health System Performance
- Theme 2 - Improving Health Care Financing and Delivery Mechanisms
- Theme 3 - Meeting the Needs of Vulnerable Populations
- Theme 4 - Information to Improve Consumer Choice and Health Status

The synopsis of each project includes an identification number, project title, project number, project period, name of principal investigator, and the name and address of its awardee, contractor, or grantee organization. Also included is the name of the Federal project officer with primary responsibility for the project, the Federal statute under which it was conducted (if applicable), the status of the project as of December 31, 1997, and a brief description of each project's goals and its design.

In addition to these focused research and demonstration projects summaries, this report also includes summaries of HCFA awards under its Small Business Innovation Research Grant Program; the Dissertation Fellowship Grant Program; and research and demonstration task order contracts. Several indices are provided to help readers identify specific projects, principal investigators, awardee organizations and project officers.

This is the eighteenth edition of the *Active Projects Report* (formerly the *Status Report: Research and Demonstrations in Health Care Financing*). An updated edition is produced each year.

For more information about HCFA and its research and demonstrations program, contact the HCFA Web site at: **http://www.hcfa.gov.**


HEALTH CARE FINANCING ADMINISTRATION
Organization Chart
PRESS OFFICE
ADMINISTRATOR
OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS
CENTER FOR BENEFICIARY SERVICES
CENTER FOR HEALTH PLANS AND PROVIDERS
CENTER FOR MEDICAID AND STATE OPERATIONS
OFFICE OF LEGISLATION
OFFICE OF STRATEGIC PLANNING
OFFICE OF THE ACTUARY
OFFICE OF CLINICAL STANDARDS AND QUALITY
OFFICE OF COMMUNICA-TIONS AND OPERATIONS SUPPORT
CHIEF OF OPERATIONS
OFFICE OF FINANCIAL MANAGEMENT
OFFICE OF INFORMATION SERVICES
OFFICE OF INTERNAL CUSTOMER SUPPORT
NORTHEASTERN CONSORTIUM
SOUTHERN CONSORTIUM
MIDWESTERN CONSORTIUM
WESTERN CONSORTIUM
REGIONAL & FIELD OFFICES
REGIONAL & FIELD OFFICES
REGIONAL & FIELD OFFICES
REGIONAL & FIELD OFFICES

Theme 1: Monitoring and Evaluating Health System Performance

As the United States health care system continuously changes, there is a clear need for the development, design, and testing of ways to monitor and evaluate its activity. The monitoring and evaluation of the Health Care Financing Administration's (HCFA) programs is a key part of its research agenda. A number of critical dimensions must be included in our monitoring and evaluation efforts to understand, on an ongoing basis, how well the public programs are performing in terms of access to care, quality, efficiency, costs, and beneficiary satisfaction. As part of this activity, it is vitally important to develop a wider array of evaluation and measurement tools. These techniques must address the large volumes of data often associated with program monitoring and evaluation efforts. Our research under *Theme 1* therefore includes two related efforts: monitoring and evaluating the public programs, and developing monitoring and evaluation tools. This latter area includes research to develop meaningful outcome and access indicators, the necessary databases, techniques for handling large volumes of data, statistical approaches, and ongoing reporting systems.

95-056 International Comparative Data and Analysis of Health Care Financing and Delivery Systems

Project No.:	500-95-0001
Period:	August 1995-August 2000
Funding:	$1,455,100
Award:	Contract
Principal Investigator:	Jean Pierre Poullier
Awardee:	Organization for Economic Cooperation and Development 2 Rue Andre Pascal 75775 Paris Cedex 16 France
HCFA Project Officer:	Leslie M. Greenwald, Ph.D. Office of Strategic Planning
Mandates:	The Omnibus Budget Reconciliation Act of 1990

Description: The Organization for Economic Cooperation and Development (OECD) has developed a unique database that contains information on health care financing and use in industrialized Western nations. The OECD will collect data on the following member countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom, and the United States. This project obtains these data on an ongoing basis and updates and expands them, along with a series of papers analyzing the trends in Western-developed nations and their policy relevance to the United States. The importance of these data, in particular, is that they are the only country-to-country comparable figures (in terms of general definitions of health spending and methodology of their collection) of this type.

Variables in the annual database include individual country comparisons of: total health care expenditures; expenditures on various parts of health care spending, such as hospital or physician services; health outcomes measures, such as infant mortality rates and life expectancy; and country-specific economic indicators and demographic data. Together, these data are the source of statistics comparing health spending (usually expressed as a percentage of gross domestic product, or in U.S. dollars per capita) in the United States and other Western developed nations. In general, these data have for a number of years shown that U.S. spending, even when controlling for population and total gross domestic product, is far above that of other developed nations.

Status: Data for 1960-1996 are generally available for most variables.

97-021 State Long Term Care Policy and Program Information Data Collection Project

Project No.:	500-97-0002
Period:	July 1997-July 2000
Funding:	$370,705
Award:	Contract
Principal Investigator:	Charlene Harrington
Awardee:	University of California at San Francisco

	3333 California Street San Francisco, CA 94143-0962
HCFA Project Officer:	Kay Lewandowski Office of Strategic Planning

Description: This project will collect data on and study the effects of nursing home and home health care characteristics and markets on Medicare and Medicaid services in the 50 States. Primary and secondary data for the 1995-1997 period will be collected to update earlier data in previous studies for the 1978-1994 period. Through surveys, data will be collected on licensed nursing home bed supply and occupancy rates, State certificate of need programs, State preadmission screening programs, and Medicaid nursing home and home health reimbursement. Data also are being collected on Medicaid waiver programs, provider characteristics, resident characteristics, and deficiencies of nursing homes. Analysis will provide detailed information on each State's current methodology for determining nursing home capital costs, the impact of proposed case-mix reimbursement on operating income, reimbursement methodology for freestanding subacute units, and Medicaid methodology used to reimburse for care provided in board and care homes, geriatric day care centers, and intermediate care facilities for the mentally retarded. A publicly accessible database will be developed that will provide a complete set of data for the period 1978-97.

Status: Data collection for this study started in July 1997. A draft data book will be prepared in the summer of 1998.

94-113 **National Recurring Data Set Project: Ongoing National State-by-State Data Collection and Policy/Impact Analysis on Residential Services for Persons with Developmental Disabilities**

Project No.:	HCFA-IA-94-85
Period:	October 1996-September 1997
Funding:	$35,000
Award:	Interagency Agreement
Principal Investigator:	Charlie Lakin, Ph.D.
Awardee:	University of Minnesota Institute of Community Integration 150 Pillsbury Drive, SE. Minneapolis, MN 55455
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning

Description: This interagency agreement supported secondary data analyses and the production of a report that describes and updates the status of persons with mental retardation and related conditions (MR/RC) in institutional care facilities for the mentally retarded (ICF-MRs), Medicaid waiver programs, and nursing homes funded under the Medicaid program to assist in the evaluation of Medicaid services for persons with MR/RCs and to point out areas in need of reform. The report included the following:

- Background description of the key Medicaid programs of interest.
- State-by-state and national statistics on ICF-MRs, Medicaid home and community-based services, and nursing home use.
- Description of the characteristics of ICF-MRs and their residents, with comparative statistics for noncertified facilities.

Status: The University of Minnesota continued to collect data to produce its annual report on the status of the Medicaid programs that serve the developmentally disabled. This Agreement expired this year and was replaced to continue the access to these data. See 97-020.

97-020 **National Recurring Data Set Project**

Project No.:	HCFA-IA-97-70
Period:	June 1997-September 1999
Funding:	$50,000
Award:	Interagency Agreement
Principal Investigator:	Leola Brooks
Awardee:	ADD/University of Minnesota 150 Pillsbury Drive, SE. Minneapolis, MN 55455
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning

Description: This interagency agreement continues to support secondary data analyses and the production of a report that describes and updates the status of persons with mental retardation and related conditions (MR/RC) in institutional care facilities for the mentally retarded (ICF-MRs), Medicaid waiver programs, and nursing homes funded under the Medicaid program to assist in the evaluation of Medicaid services for persons with

MR/RCs and to point out areas in need of reform. The report includes the following:

- Background description of the key Medicaid programs of interest.
- State-by-state and national statistics on ICF-MRs, Medicaid home and community-based services, and nursing home use.
- Description of the characteristics of ICF-MRs and their residents, with comparative statistics for noncertified facilities.

Status: The University of Minnesota continues to collect data to produce its annual report on the status of the Medicaid programs that serve the developmentally disabled. The preceding project was 94-113.

IM-006 **Longevity and Medicare Expenses**

Funding:	Intramural
HCFA Project Director:	James D. Lubitz Office of Strategic Planning (with Brenda Spillman and Judy Sangl, Agency for Health Care Policy and Research)

Description: Little is known about the relationship between longevity and lifetime Medicare costs. This study uses the Continuous Medicare History Sample, a longitudinal file covering years 1974-90, to estimate Medicare payments for persons dying from 65 years of age to over 100 years of age. It simulates lifetime Medicare payments under various future longevity scenarios.

Status: Results were published in an article, "Longevity and Medicare Expenditures," in the April 13, 1995, issue of the *New England Journal of Medicine*. The study found that, compared to the large effect on Medicare expenditures from increased number of enrollees, increased longevity will have relatively little effect on the Medicare budget. A follow-up study, conducted in collaboration with the Agency for Health Care Policy and Research, is examining lifetime expenses for all health care services for the elderly, including Medicare-covered services, nursing home services, prescription drugs, and home health care. Expenses under different longevity scenarios will be simulated. The study also examined patterns of health care expenses in the last years of life for various services. A draft of this paper has been completed.

IM-052 **Monitoring Changes in Self-Reported Access to Care among Medicare Beneficiaries**

Funding:	Intramural
HCFA Project Director:	Thomas W. Reilly, Ph.D. Center for Beneficiary Services

Description: Efforts to monitor access in Medicare need to include information from beneficiaries on their experiences in obtaining care covered by the program. This study will examine data from the Medicare Current Beneficiary Survey on issues such as availability of care and perceived barriers to care. The study will track responses over time for the overall Medicare population and for potentially vulnerable subgroups.

Status: The study is in the design phase.

IM-053 **Monitoring Access to Physician Services among Vulnerable Subgroups of the Medicare Population: Controlling for the Underlying Need for Services**

Funding:	Intramural
HCFA Project Director:	Thomas W. Reilly, Ph.D. Center for Beneficiary Services

Description: A number of prior studies have attempted to evaluate access to physician services under Medicare by examining group differences in patterns of use. The problem with such analyses is that one often does not know whether differences in use reflect differences in access to care or differences in the underlying need for services. This project will isolate differences in access by comparing patterns of use within populations with comparable need for services. It will begin by examining the probability of obtaining follow up care after a hospitalization for congestive heart failure. Since all such patients should receive a follow up visit with a physician within 30 days, differences in follow up care more clearly reflect differences in access rather than differences in the underlying need for services. The project will especially focus on whether potentially vulnerable subgroups are less likely to obtain needed care.

Status: The study is in the design phase.

IM-054 Monitoring Needs Not Met by Medicare: An Examination of the Use of Non-Covered Services among Medicare Beneficiaries

Funding:	Intramural
HCFA Project Director:	Thomas W. Reilly, Ph.D. Center for Beneficiary Services

Description: One important aspect of access to care for Medicare beneficiaries involves the extent to which needed services are, or are not, covered by the program. This project will monitor the use of non-covered services among Medicare beneficiaries, using data from the Medicare Current Beneficiary Survey. It will identify areas of high use/expenditure for the overall Medicare population and for potentially vulnerable subgroups. These analyses will help identify important gaps in Medicare coverage and identify subgroups of beneficiaries with relatively high levels of need for services not currently covered by the program. Tracking changes in patterns of use over time will help identify areas of growing need unmet by Medicare.

Status: The study is in the design phase.

IM-055 Evaluating the Effects of Physician Payment Reform on Access: Time Series Analyses of Hospitalizations for Ambulatory Care-Sensitive Conditions

Funding:	Intramural
HCFA Project Director:	Thomas W. Reilly, Ph.D. Center for Beneficiary Services

Description: This project evaluates the effects of physician payment reform (PPR) on access to care in the Medicare population by studying patterns of hospitalization for ambulatory care-sensitive (ASC) conditions. If there is a decrease in access to needed ambulatory care services associated with PPR, one would expect to see an increase in hospitalizations for ASC conditions following the implementation of PPR. This project will analyze the trend in rates of hospitalization for selected ASC conditions to see whether there is a discontinuity in the time series associated with the implementation of PPR.

Status: The analysis has been completed and a paper was published in the *Health Care Financing Review*, Winter 1995.

IM-010 Monitoring Utilization of and Access to Services for Medicare Beneficiaries under Physician Payment Reform

Funding:	Intramural
HCFA Project Director:	Ann Meadow, Sc.D. Office of Strategic Planning
Mandate:	Omnibus Budget Reconciliation Act of 1989

Description: The Omnibus Budget Reconciliation Act of 1989, specified a new payment system, the Medicare Fee Schedule (MFS), for Medicare physicians' services. This intramural project is one of several analyzing effects of the new system on access to care. The work focuses on access impacts of the MFS from the perspective of the physician. Although population-based use data can measure access as an outcome, such information does not explain the process by which physicians respond to policy change and thereby influence access. This project analyzed all available Medicare Part B claims from a panel of physicians identified by their unique physician identification number. The first phase of the study analyzed 2 years of data (1991-1992) from a panel comprising 7,361 physicians in 18 selected States. The second phase analyzed 2 years of data (1992-1993) from a dynamic panel of approximately 18,000 physicians in 36 States, and included allowed-charge data from 100 percent of physicians in 29 of those States. Additionally, the study examined 3-year trends in 15 States with claims data adequate for analysis back to 1991, which was the final year before implementation of the MFS. The study's emphasis in the first two phases was on measuring change in several key access-related measures. The measures were caseload (i.e., number of beneficiaries treated in a year), continuity in performing specific procedures, total allowed charges, and assigned charges as a proportion of allowed charges. The third phase, conducted in 1996, was limited to review of caseload and allowed charges for 1992-94.

Status: Data from the study's second and third phases have tended to indicate modest growth in caseload per physician of about 2 to 3 percent per year in the 36 study areas as a whole. Subtotals for six major specialty categories often exhibit trajectories of growth in 1 year and little or no change in another. Data on allowed charges per physician suggest that, while allowed charges tended to change little in 1992-93, growth

picked up in 1993-94. Indicators for both caseload and allowed charges so far suggest that access to physician services has not deteriorated following introduction of the MFS. Physicians' willingness to see Medicare patients, as revealed in caseload movements, does not appear to have lessened, in view of the stability or improvement in caseload measures. The 1993-94 gains in revenues for Medicare physicians may be taken to indicate that Medicare's economic importance to the physician is probably not waning. The next phase of the study is underway. It will incorporate physician sample data for 1995 and 1996.

First-, second-, and third-phase findings were included in three successive Reports to Congress, "Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access" (1994, 1995, and 1996). A review of selected findings for 1991-93 was published in the *Health Care Financing Review* ("Access to Care Under Physician Payment Reform: A Physician-Based Analysis," Winter 1995).

IM-065 Use of Mental Health Services by Medicare Enrollees

Funding:	Intramural
HCFA Project Directors:	Carlos Cano, Jay Bae, Ph.D., Joan Warren, Ph.D., and James D. Lubitz Office of Strategic Planning

Description: Mental health service use is of policy interest because of changing attitudes among the elderly on mental health services, because of the liberalization of Medicare coverage for outpatient mental health service, because of the growth in partial hospitalization, and because of the increasing role of managed care in mental health delivery to the non-Medicare population. This study will examine the use and cost of Medicare-covered mental health services. It will analyze use by diagnosis, type of service (e.g. inpatient, outpatient, etc.), and by beneficiary characteristics such as age and whether entitled due to old age or disability.

Status: A study of inpatient hospital use for psychiatric diagnoses has been completed and the results published in the *Health Care Financing Review*, Spring 1997, ("Medicare Part A Utilization and Expenditures for Psychiatric Services: 1995" authored by Kevin Hennessy, Joan Warren, Jim Lubitz and Carlos Cano). The project now moves to an examination of mental health service use in physician and outpatient settings.

IM-025 Upper Gastrointestinal Endoscopy in the United States: Geographic Variation in Practice Patterns

Funding:	Intramural
HCFA Project Director:	Renee Mentnech Office of Strategic Planning

Description: Upper esophagogastroduodenoscopy (EGD) is a commonly performed procedure with well-defined indications. However, little is known about the practice patterns for this procedure, specifically the number performed. The purpose of this study is to examine variations in the use of endoscopy on Medicare patients in the United States and how variations in endoscopy rates relate to variations in the rates of hospitalizations for gastrointestinal disorders. Use of upper gastrointestinal X-rays will also be incorporated into the analysis to determine whether these two services are being used as substitutes for each other.

Status: All aged Medicare patients who underwent EGD and upper gastrointestinal X-ray in 1993 were identified by using Current Procedural Terminology codes. Rates of endoscopy and upper gastrointestinal X-ray for the top 50 metropolitan statistical areas by gender and race are being developed. Hospitalization rates for diagnoses for which an EGD is indicated are also being compared. The supply of gastroenterology training programs for physicians is being examined to determine the effect on utilization. A paper is being prepared.

IM-012 Patterns and Outcomes of Cancer Care in the Medicare Population

Funding:	Intramural
HCFA Project Directors:	Gerald F. Riley, James D. Lubitz, and Renee Mentnech Office of Strategic Planning

Description: More than one-half of all cancer patients have Medicare coverage. A database that links Medicare data with cancer registry data collected through the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program has been created. The SEER program covers approximately 10 percent of the U.S. population. This database contains information on the anatomic site of the primary cancer, histology, stage

of the disease at diagnosis, and date of diagnosis for each new case of cancer in the program's geographic areas. Linking SEER and Medicare data provides opportunities for research on issues of access to medical care, Medicare costs incurred by cancer patients, and patterns of medical care received by cancer patients diagnosed with various sites, stages, and histologies of cancer. Some specific questions to be addressed are the following:

- What are overall Medicare costs, by type and stage of cancer?
- What are the Medicare costs that are specifically related to cancer care?
- What comorbidities are associated with cancer and how do they influence Medicare use and cost?
- What is the mix of care (on a per-person basis) among community hospitals, teaching hospitals, and cancer centers?
- What are the institutional factors that influence the type of inpatient hospital care received by cancer patients?

Status: SEER data have been linked to Medicare administrative records for cancer cases diagnosed through 1993. An update of the linkage, which will incorporate SEER cancer cases diagnosed in 1994-1996, is planned for late 1998.

IM-074 **Breast Cancer Treatment Patterns among Medicare Enrollees in HMOs and Fee-for-Service**

Funding:	Intramural
HCFA Project Director:	Gerald Riley Office of Strategic Planning

Description: Differences in treatment patterns between health maintenance organization (HMO) and fee-for-service (FFS) settings are of interest because of implications for quality and costs of care. This study uses tumor registry data from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program linked with Medicare administrative records to examine the use of breast conserving surgery (BCS) vs. mastectomy for early stage breast cancer cases in HMOs and FFS. The study also examines the use of adjuvant radiation therapy among BCS patients. The study includes all early stage breast cancer cases diagnosed in 1988-1993 among elderly women entitled to Medicare who resided in SEER reporting areas. The study also compares the distributions of stage at diagnosis between HMO and FFS enrollees.

Status: Preliminary results suggest similar use of BCS among women in HMOs and FFS across the eight geographic areas included in the study, but use of BCS was greater or less in HMOs than in FFS in certain geographic areas. Among women undergoing BCS, there was slightly greater use of radiation therapy among HMO enrollees, but this finding also differed by geographic area. Women enrolled in HMOs tended to be diagnosed at earlier stages than women in FFS. The study will explore HMO characteristics associated with greater use of BCS and radiation therapy. The study is expected to be completed in 1998 or early 1999.

IM-044 **Utilization Patterns and Volume Stability at the Oncology Firm Level for Treatment of Medicare Beneficiaries with Cancer**

Funding:	Intramural
HCFA Project Director:	Teresa DeCaro Center for Health Plans and Providers

Description: Patterns of care and volume stability at the physician organization level will be studied using per-capita measures of utilization for selected oncology services and for all Medicare services. The effect of the principal provider organization's characteristics, size, and case mix of oncology practice, and geographic location on per capita-costs will also be examined. These analyses will support the development of alternative service bundles and carve out payments for the care of Medicare cancer patients. The Medicare-surveillance epidemiology and end result program database will be the principal source of data.

Status: This project is in an early development phase.

IM-067 **Dialysis Modality Selection among Patients Attending Freestanding Dialysis Facilities**

Funding:	Intramural
HCFA Project Director:	Michael Kendix, Ph.D. Office of Strategic Planning

Description: Persons with end-stage-renal-disease (ESRD) are eligible to receive dialysis services under the Medicare program. An individual-level analysis was performed to determine the factors associated with the

modality selected by patients; namely in-center hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), and home hemodialysis. A series of logistic regressions was estimated using program data for 73,448 ESRD Medicare patients attending freestanding dialysis facilities. The results showed first, that ethnic minorities are less likely to select CAPD, CCPD, and home hemodialysis. Second, income was positively associated with selecting a home-based modality. Third, patients attending for-profit dialysis facilities were less likely to select CAPD, CCPD, and home hemodialysis. Fourth, patients attending facilities owned by a large chain were less likely to select CAPD and home hemodialysis, but more likely to select CCPD. Fifth, patients who were younger, had non-systemic precipitating causes of ESRD, and a shorter duration of ESRD were more likely to select CAPD and CCPD. Sixth, women were more likely to select CAPD and less likely to select home hemodialysis. Finally, patients in larger facilities are more likely to select CAPD, CCPD, and home hemodialysis; that is, there are economies of scale with respect to these modalities being selected.

Status: A paper, "Dialysis Modality Selection Among Patients Attending Freestanding Dialysis Facilities," was published in the *Health Care Financing Review*, Summer 1997.

IM-068 Persons With Acquired Immune Deficiency Syndrome in the Medicare Program

Funding:	Intramural
HCFA Project Director:	Michael Kendix, Ph.D. Office of Strategic Planning

Description: This project will evaluate the use of Medicare program services for persons with AIDS. The study will identify health services utilization, access to care, and reimbursement patterns of persons with AIDS in the Medicare program.

Status: The project was ongoing as of December 1997.

96-053 Analysis of Patterns of Payments, Users and Payments per User for Disabled Medicaid Enrollees by Age Group

Project No.:	500-96-0026-0003
Period:	September 1996-January 1997
Funding:	$16,073
Award:	Task Order
Principal Investigator:	George Kowalczyk
Awardee:	Jing Xing Health and Safety Resources, Inc. 7008-K Little River Turnpike Annandale, VA 22003
HCFA Project Officer:	David K. Baugh Office of Strategic Planning

Description: This task order used State Medicaid Research Files data to produce basic descriptive data on payments, user, and payments on selected Medicaid services by age group for further development of hypotheses and analyses as we refine our understanding of the patterns found.

Status: The project is completed. The contractor prepared data tabulations for selected States using the State Medicaid Research Files.

IM-046 Study of Access to Durable Medical Equipment by Non-Aged Disabled Medicare Beneficiaries

Funding:	Intramural
HCFA Project Director:	William D. Clark Office of Strategic Planning

Description: This project is intended to examine access to durable medical equipment (DME), especially wheelchairs, by non-aged disabled Medicare beneficiaries to determine whether changes in access have resulted from DME payment changes in the Medicare program. The study will use Medicare data from 1991 through 1995 to assess changes in assignment rates, payment denials, and supplier characteristics and other variables.

Status: A project design and data request were prepared. Initial discussions with industry and advocacy group representatives were held. However, the project was canceled due to lack of staff resources.

IM-059 Childhood Injuries in the Medicaid Population

Funding:	Intramural
HCFA Project	David Baugh and Rosemarie Hakim,

Ph.D.

Director Office of Strategic Planning
Suzanne Rotwein, Ph.D.
Center for Beneficiary Services

Description: Injuries are a significant cause of mortality and morbidity in the U.S. population, particularly among persons under 21 years of age, and among the vulnerable populations served by Medicaid. Little is known about the incidence, prevalence, and program expenditures for injuries under Medicaid. This study will provide baseline data on utilization and payments for injuries by Medicaid in selected States. Since many injuries are preventable, this effort will lead to other studies that should assist us in understanding the extent and types of injuries experienced by Medicaid enrollees and provide input to a process of preventing injuries and containing cost for injuries within Medicaid.

Status: A review of the International Classification of Diseases, 9th Revision, Clinical Modification codes has been completed to identify injuries from the E800-E999 series (supplementary classification of external causes of injuries and poisonings), the 800-999 series (injury and poisoning) and selected other codes outside these series. This work has been accomplished in consultation with experts in injury coding from the National Center for Health Statistics. The complete list of codes has been collapsed into both a long and a short list of code groups which represents a classification or taxonomy of injuries by type. Criteria have been prepared for the selection of Medicaid claims data records for injuries from both inpatient hospital and outpatient State Medicaid Research Files (SMRFs). Initial testing of the extraction and tabulation specifications is now being conducted on SMRF data.

IM-070 **The Health of Poor Children in the United States**

Funding: Intramural
HCFA Project Director: Rosemarie Hakim, Ph.D.
Office of Strategic Planning

Description: The project will use the National Health and Nutrition Examination Survey III data set to describe health markers of children at various income levels. This is a cross-sectional, nationally representative study that can provide extensive information on the health status of Medicaid, uninsured, and privately insured children. The information available in this survey will allow for exploration of a large number of variables that influence the health of children, including insurance status, race, barriers to care, and use of health services. Health outcome indicators will include morbidity, including lead poisoning, anemia, injuries, and asthma, growth and development, and mortality. The denominator population will be U.S. population of children, 17 years of age and under. The information can be used to estimate the percentage of children using Medicaid services, and the extent of health problems among the insured and uninsured.

Status: Analysis began in November 1996 and was continuing as of December 1997.

IM-071 **Racial and Payer Differences in Infant Mortality in a National Sample of Preschool Children**

Funding: Intramural
HCFA Project Director: Rosemarie Hakim, Ph.D.
Office of Strategic Planning

Description: The project will use the National Maternal and Infant Health Survey database to analyze factors associated with infant mortality. Information on health insurance coverage, income, and use of prenatal services are available in this survey. Co-factors that vary between racial and income groups are available in this data set including race, barriers to care, and maternal factors will be used to predict infant mortality in each payer, race, and income group.

Status: Analytical files are currently under review.

IM-072 **Longitudinal Study of Use of Early Preventive Services and Health Outcomes of a Nationally Representative Cohort of Children Born in 1988 and Followed Up at Age Three**

Funding: Intramural
HCFA Project Director: Rosemarie Hakim, Ph.D.
Office of Strategic Planning

Description: The project will use the National Maternal and Infant Health Survey and the 1991 Longitudinal Follow Up Survey to examine the effects of use of early preventive health care on health outcomes to test the hypothesis that adequate use of services improves the health and well-being of children. The survey contains

extensive provider information as well as interview-based information on each child's health and use of services. Children covered under private insurance, Medicaid, and uninsured are in the sample. Health outcomes will include growth and cognitive development, as well as common child health indicators such as immunizations and respiratory infections. Factors such as barriers to care, income, race, and continuity of care can be used to predict health outcomes.

Status: This project is a joint effort between HCFA and the National Center for Health Statistics.

IM-061 Patterns of Use and Payments for Disabled Medicaid Enrollees

Funding:	Intramural
HCFA Project Director:	David K. Baugh Office of Strategic Planning

Description: This project is investigating the level of Medicaid payments, number of users (of specific services), and payments per user for subgroups of Medicaid disabled enrollees. It is important to understand utilization and payment variation for different groups within the Medicaid-enrolled population. It is also important to understand the extent of variation for these groups across States and over time. A better understanding of the variations and the factors that cause (or correlate with) them will help in several areas:

- Explaining trends in program spending growth.
- Developing estimates of cost for disabled groups and disabling conditions.
- Comparing Medicaid to other non-Medicaid populations.
- Identifying special needs of Medicaid disabled subgroups.
- Determining if important gaps exist in coverage and/or access.
- Conducting comparisons for disabled individuals under fee-for-service versus managed care.
- Assessing the equity proposed rates for prepaid plans.

This work used data from Medicaid Statistical Medicaid Research Files to produce basic descriptive data on payments, users, and payments per user for selected Medicaid services by age group. While the data were produced for all age groups, analyses focused on disabled children. These data provided initial benchmarks on utilization and payments for disabled subgroups that was foundational. While these data are useful on their own, they can lead to further development of hypotheses and analyses as we refine our understanding of the patterns we see.

Status: Data tabulations were completed in the spring of 1997.

IM-040 A Comparative Analysis of Formulas Used by Medicaid and Private Payers to Reimburse Pharmacists for Outpatient Prescription Drugs

Funding:	Intramural
HCFA Project Director:	Kathleen Gondek, Ph.D. Office of Strategic Planning

Description: The objective of this study was to compare and contrast insurance plan characteristics and payment formulas used by Medicaid and private third-party payers to reimburse pharmacies for outpatient prescription drugs. Information obtained included the geographic area served, total number of enrollees, cost-containment provisions, claims processing methods, and payment formulas. A market basket of 25 drugs was randomly selected from the top 100 drugs by dollar rank from Medispan for the last quarter of 1993 to illustrate the impact of payment formulas on reimbursement. The payment formulas used by a total of 95 plans—45 private and 50 Medicaid—were examined. The plans were ranked on the generosity of their formulas.

Status: A paper is currently under review for publication.

IM-038 Drug Patent Expirations and the Speed of Generic Entry

Funding:	Intramural
HCFA Project Director:	Jay Bae, Ph.D. Office of Strategic Planning

Description: When patents expire on prescription drugs, other firms may market chemically identical versions as generic drugs. This project examines the phenomenon of generic drug entry between 1987 and 1994. Recognizing the entry phenomenon as a dynamic process that occurs

over time, this study evaluates the entry and non-entry cases in a duration model. The estimation resulted in the following findings:

- There is a negative relationship between the innovative drug's sales revenue and the time to generic entry. In other words, the drugs that generate more revenue attract more rapid generic entries.
- The drugs that primarily treat chronic symptoms have quicker entries than the types of drugs that primarily treat acute illness.
- The generic entries became less likely and the time delay increased during the data period. This is a reversal of the trend observed between 1983 and 1987 by Grabowski and Vernon.
- Entry barriers for generic drugs seem to be non-monotonic in the number of existing branded products in a therapeutic market.

Status: The final report was completed and a paper published. "Drug Patent Expirations and the Speed of Generic Entry," Bae, Jay, *Health Services Research*, April 1997.

94-083 **Changing Roles of Nursing Homes**

Project No.:	17-C-90428/5
Period:	September 1994-June 1998
Funding:	$831,182
Award:	Cooperative Agreement
Principal Investigator:	Brant Fries, Ph.D.
Awardee:	Institute of Gerontology University of Michigan 300 North Ingalls Building, Room 900 Ann Arbor, MI 48109-2007
HCFA Project Officer:	Paul W. Eggers, Ph.D. Office of Strategic Planning

Description: Although nursing homes have traditionally provided custodial care to the physically and cognitively impaired elderly, nursing homes are increasingly treating a more diverse and more clinically complex patient mix. Since the implementation of Medicare's prospective payment system for hospitals, growing numbers of nursing homes have begun caring for patients requiring "subacute" or post-acute care following a hospital stay. Between 1986 and 1993, the number of Medicare-certified hospices in the U.S. grew from 355 to 1,445. From 1992 to 1995, the number of special care hospice units in nursing homes grew 100 percent, to 206.

This study examines two special nursing home populations: hospice patients and the chronically mentally ill (other than dementia). Several hypotheses regarding quality, use, and cost issues will be examined for both groups, such as that residents with chronic mental illness are more likely than are other similarly functionally impaired residents, to experience increasing functional impairment, to have increased behavior problems and to be chemically restrained. It is hypothesized that mentally ill patients will have greater overall use of Medicare services than will non-mentally impaired nursing home residents with similar levels of functional impairment. The study utilizes 1993 data on the entire nursing home populations of eight States (Kansas, Maine, Mississippi, Nebraska, New York, Ohio, Pennsylvania, South Dakota, and Washington), about 250,000 residents, linked with HCFA Survey and Certification Reports, the Medicare Part A and Part B claims files and the Area Resource File data. The Minimum Data Set for Nursing Home Resident Assessment and Care Screening is used to collect health status data on all residents in Medicaid-certified, Medicare-certified and dually certified nursing facilities. The hospice substudy will describe how nursing home hospice services are concentrated in particular regions, markets and facilities; compare rates of hospital use and costs of terminal care residents in nursing homes that do and do not use the Medicare hospice benefit; and describe the quality of life, including pain experience and analgesics prescribed among terminal cancer patients in nursing homes who are served by hospice care and those not so served.

Status: A draft report, "Hospice in Nursing Homes," presents initial analyses of longitudinal files of 1991-95 nursing home survey data merged with patient assessment data. Multivariate analyses indicate that hospice special care units are located in relatively small and medium size facilities with low occupancy, high technological capacity and a higher skill level of staffing mix. Also, nursing home characteristics, such as being a proprietary facility, not part of a chain and being located in a competitive environment, are significantly related to having a hospice special care unit. The authors note that the growth in special care hospice units in nursing homes reflects changes in reimbursement mechanisms, increases in the proportion of all deaths occurring in

nursing homes, and by nursing home efforts to specialize. A paper, "Special Populations in Nursing Homes: Residents with Chronic Mental Illness or Developmental Disabilities," was presented at the November 1996 meeting of the Gerontological Society of America.

97-014 **Hospital Cost Monitoring**

Project No.:	500-97-0001
Period:	April 1997-March 1998
Funding:	$163,375
Award:	Contract
Principal Investigator:	Alan Bardauskis
Awardee:	American Hospital Association 840 North Lake Shore Drive Chicago, IL 60611
HCFA Project Officer:	Benson L. Dutton Office of Strategic Planning

Description: The purpose of this contract is to obtain data from the American Hospital Association's Annual Survey of Hospitals and the National Monthly Hospital Panel Survey. These data will be used for research, actuarial studies, policy development involving cost, expenditure, service, and utilization analyses. This will be the fourth in a series commencing in 1980 through 1996.

Status: Thus far fourth quarter 1996 and first quarter 1997 data from the AHA National Panel Survey have been delivered.

IM-005 **Financial Ratios: Implications for Assessment of Hospital Profitability and Efficiency**

Funding:	Intramural
HCFA Project Director:	William Buczko, Ph.D. Office of Strategic Planning

Description: This project examines the utility of financial ratios for assessment of hospital financial status and compares several ratios measuring aspects of financial performance using Medicare Cost Report data.

Status: Analysis of Medicare patient margin and total facility margin data to assess hospital profitability is ongoing. "Allowances on Patient Accounts and Hospital Profitability," a paper examining discounting of patient charges and its effect on hospital financial performance, was presented at the 1995 Annual Meeting of the American Public Health Association. Further research will examine additional financial indicators using updated cost report data.

IM-034 **Determinants of Home Health Use**

Funding:	Intramural
HCFA Project Officer:	Elizabeth Goldstein, Ph.D. Center for Beneficiary Services

Description: Modifications in the eligibility requirements for Medicare home health services, implementation of the Medicare prospective payment system in hospitals, and beneficiary preferences to remain in the community have resulted in significant increases in Medicare home health care expenditures. Although Medicare home health expenditures continue to rise, relatively little is known about home health users and the market characteristics that affect home health use. Consequently, HCFA has implemented several intramural research studies to support future efforts of payment reform in the area of post-acute care. Using the Medicare Current Beneficiary Survey (MCBS) and home health claims data, this study is exploring the following issues:

- Whether home health users can be classified into distinct subgroups to understand the special care needs of home health users, determine how specific policies affect different groups of users, and develop case-mix adjustments for payment reform.
- How home health use has changed over time, using the 1991, 1992, and 1993 MCBS.
- The effect of supply factors on home health use by linking the MCBS with the area resource file.
- The extent of substitution among different post-acute care settings, such as skilled nursing, home health, and rehabilitation facilities.

Status: A number of these analyses are ongoing. The research to date suggest that it is not possible at home health admission to predict the group of home health users who will require care for an extended period of time.

94-075 **Development of a Global Quality Assessment Tool for Managed Care**

Project No.:	18-C-90315/9

Period:	September 1994-September 1999
Funding:	$1,579,386
Award:	Cooperative Agreement
Principal Investigator:	Elizabeth McGlynn, Ph.D.
Awardee:	The Rand Corporation 1700 Main Street Santa Monica, CA 90407-2138
HCFA Project Officer:	M. Beth Benedict, Dr.P.H. Office of Strategic Planning

Description: This project will develop and test a clinically based method for assessing the quality of care delivered for a broad range of services in managed care health plans. It will focus on the quality of care delivered to children and to women under 45 years of age.

Status: The clinical criteria have been developed. Testing is anticipated to begin in the summer of 1998.

95-046 **Understanding Properties of the Unique Physician Identification Number for Claims-Based Research**

Project No.:	500-92-0020/14
Period:	August 1995-January 1997
Funding:	$177,063
Award:	Delivery Order
Principal Investigator:	Killard W. Adamache, Ph.D.
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Ann Meadow, Sc.D. Office of Strategic Planning

Description: The Unique Physician Identification Number (UPIN) was established in 1989 to support a national identifier system for Medicare physicians. In 1992, HCFA directed carriers and billers to use the UPIN on physician/supplier Medicare claims to identify performing and referring physicians. HCFA contracted with Health Economics Research, Inc., to perform several studies of UPIN-related data on claims and on the UPIN Registry. The purposes of this delivery order are to:

- Investigate the strengths and limitations of the UPIN as a research tool--one which has been implemented within a complex, decentralized administrative system oriented primarily to health care claims processing.
- Improve and extend the research-related properties of the UPIN and successor identifiers such as the National Provider Identifier in the future.
- Develop background information for supporting HCFA's move to a national electronic claims-processing and practitioner/supplier enumeration system.

The project tasks were varied and included analyzing data from claims and physician-enumeration files to assess their accuracy and completeness; gathering background information on carrier operations that have significance for interpreting UPIN-related data; and conducting discussions with selected State licensing boards about license number assignment and technologies with potential to support license verification procedures.

Status: This project has been completed. Findings are described in two reports, "Understanding Properties of the UPIN for Claims-based Research: Final Interim Report," (October 1996) (National Technical Information Service accession number, PB98-118425) and "Understanding Properties of the UPIN for Claims-Based Research: Final Report" (February 1997) (a National Technical Information Service accession number is pending).

Analysis of the use of carrier-assigned billing numbers on Part B claims and on the UPIN Registry revealed that billing numbers often could not be matched to the Registry record (Interim Report, Ch. 3). Also, the case study carriers varied considerably in their criteria for establishing practice setting records in their provider files and on the Registry (Interim, Ch. 4). These results implied that, in the majority of States, studies of service delivery at the physician's practice setting level would be difficult to conduct using administrative data. The case studies also suggested how certain claims-processing and data-entry procedures can result in discrepancies between claims and Registry data and in erroneous Registry data (Interim, Ch. 4). Reporting completeness for the referring physician on claims was found to be high: 98 percent of the Part B line items subject to Common Working File edits had a usable referring UPIN. However, a validation procedure suggested reporting accuracy might be considerably lower (Interim, Ch. 5). Discussions with several State licensing boards

uncovered wide heterogeneity in the boards' data formats, license number assignment procedures, and data exchange operations. This can lead to erroneous data on the UPIN Registry unless Medicare carrier staff maintain an extensive listing of board-specific information and are very attentive to detail when receiving and processing information (Final Report, Ch. 2). Analyses of the integrity of selected Registry data elements (State license number, ZIP Code, group practice indicator, carrier-assigned Medicare billing number) and analysis of data consistency between the Registry and claims tended to reveal considerable variation in data integrity among carriers (Final, Ch. 3). An examination of physicians with *active* status on the Registry found that nearly 30 percent had no claims activity in 1993, of whom about half comprised pediatricians, chiropractors, and oral surgeons. Registry records for these three specialties are especially liable to contain out-of-date information (Final, Ch. 4). A pilot project to collect records directly from several carriers for use in validating claims and Registry data suggested that such validation efforts can be very costly in investigator time and carrier resources (Final, Ch. 5).

96-067 Development of Comprehensive Monitoring and Evaluation Initiative for HCFA Programs

Project No.:	500-95-0056/02
Period:	September 1995-December 1997
Funding:	$249,359
Award:	Task Order
Principal Investigator:	Joyce Mann
Awardee:	The Rand Corporation 1700 Main Street Santa Monica, CA 90407-2138
HCFA Project Officer:	Penelope L. Pine Office of Strategic Planning

Description: The purpose of this contract is to study the development of monitoring systems to assess access to care, quality of care, cost as well as patient satisfaction, and outcomes for Medicare and Medicaid programs. The investigators will review existing studies and data sources and propose a conceptual framework for a comprehensive monitoring and evaluation system for HCFA programs.

In addition, this project will identify indicators for each of the major domains in the conceptual framework and discuss the strengths of each proposed indicator. Furthermore, this project will advise HCFA on options for dissemination of information from the monitoring and evaluation system.

Status: A draft report on monitoring Medicare managed care under the choices demonstrations is under review.

96-060 A Framework of Cross-Sectional and Longitudinal Issues for Analysis in the Medicare Beneficiary Health Status Registry

Project No.:	HCFA-96-0471
Period:	September 1996-July 1997
Funding:	$25,000
Award:	Purchase Order
Principal Investigator:	Barry Bye
Awardee:	Barry Bye 301 N. Beauregard Street Alexandria, VA 22312
HCFA Project Officer:	Carolyn Rimes Center for Health Plans and Providers

Description: This project was designed to evaluate the potential of the proposed Health Status Registry (Registry) to address policy-relevant priorities within the agency, i.e., managed care, outcomes of selected conditions, present alternative design, precision estimates and the impact of these on both longitudinal and cross-sectional analysis. This project initially evaluated the longitudinal analytic capabilities of the Medicare Beneficiary Health Status Registry. This paper presents a comparative analysis of the health status of Medicare beneficiaries treated in managed care and fee-for-service systems, and the health and functional status outcomes for beneficiaries in different racial groups following a hip fracture. This paper found that the Registry design did support longitudinal analyses and adequately identify health service and utilization events of current policy interest. The Registry sample size did support analyses that contrast the managed care and the fee for service environment, but that the sample size, annually and with 5-year follow-up samples may not be sufficient for short term analyses by race. Specific recommendations are provided regarding the use of outcome measures and recommendations for additional studies/evaluations are included. Because of the overlap in design focus, the resources of this project were combined with HCFA Project Number 96-047, entitled

"Analysis of Sampling and Design Issues for the Medicare Beneficiary Health Status Registry." This phase of the purchase order produced two reports entitled "Medicare Beneficiary Registry Alternative Design Approach" and "Medicare Beneficiary Registry Alternative Design Simulation." These reports assess the impact of alternative interviewing schedules on the accuracy of cross-sectional estimates at specific State levels. They found that the alternatives could provide for robust State-level estimates without compromising the capacity for longitudinal analysis. These reports are available from the project officer.

Status: The project has been completed.

96-059 **Analysis of Sampling and Design Issues for the Medicare Beneficiary Health Status Registry**

Project No.:	HCFA-96-0487
Period:	September 1996-February 1997
Funding:	$25,000
Award:	Purchase Order
Principal Investigator:	James Beebe
Awardee:	James Beebe 1345 Tydings Road Annapolis, MD 21401
HCFA Project Officer:	Carolyn Rimes Center for Health Plans and Providers

Description: This project was designed to assess and evaluate the proposed design for the Medicare Beneficiary Health Status Registry (Registry). The Registry was designed to collect information to produce longitudinal estimates. This report focuses on the potential for the Registry to produce cross-sectional estimates including:

- The use of more than 1 year of data to create cross-sectional estimates.
- Precision levels.
- Creation of cross-sectional estimates on a State basis.

Two types of estimates were considered: estimates for the 80 year old and all other ages (i.e., age 65-79). The reminder of the work in this project was completed through a joint effort. For additional details, please review the description portion of 96-060. Copies of these reports are available from the project officer.

Status: The project has been completed.

IM-056 **Non-Response Bias in the Medicare Beneficiary Health Status Registry**

Funding:	Intramural
HCFA Project Director:	Thomas W. Reilly, Ph.D. Center for Beneficiary Services

Description: HCFA is anticipating implementation of a survey to measure the health status of Medicare beneficiaries, called the Medicare Beneficiary Health Status Registry (Registry). It is important to understand differences between respondents and non-respondents in such a survey. Using Medicare claims and enrollment data, this project will compare respondents and non-respondents to the recently completed pilot test of the Registry. The study will examine factors such as patterns and types of hospitalization, ambulatory-care service use, enrollment in managed care plans, and the like. The analysis will identify potential non-response bias that might be expected in the full Registry.

Status: The study is in the design phase.

96-051 **Comparison of Enrollment Characteristics, Utilization and Expenditures for Medicaid and Federal Employees Blue Cross Blue Shield Populations**

Project No.:	500-96-0026/01
Period:	September 1996-May 1998
Funding:	$132,778
Award:	Task Order
Principal Investigator:	George Kowalczyk
Awardee:	Jing Xing Health and Safety Resources, Inc. 7008-K Little River Turnpike Annandale, VA 22003
HCFA Project Officers:	M. Beth Benedict, Dr.P.H., Melvin J. Ingber, Ph.D., and Jesse M. Levy, Ph.D. Office of Strategic Planning

Description: This task order is to provide files, programs, and analysis for a comparison of enrollment characteristics, utilization, and expenditures between Medicaid and Federal Blue Cross and Blue Shield Populations: 1989-1993.

Status: The task order contract was awarded in September 1996 concurrently with the base contract. The analyses are being conducted for risk-adjustment models.

IM-042 **The Effects of Insurance on Medical Spending Growth and the Determinants of Insurance Coverage**

Funding:	Intramural
HCFA Project Directors:	Edgar A. Peden, Ph.D. Office of Strategic Planning Mark S. Freeland, Ph.D. Office of the Actuary

Description: This project uses National Health Account data (1960 to 1993) to examine the effects of aggregate insurance coverage (the percentage of medical spending covered by third parties) on the growth in technology and, in turn, real per-capita medical spending growth in the United States. Evidence from the study indicates that insurance coverage resulted in a large part of the extraordinary growth in spending over the 34-year period studied and that, as coverage rose, so did its impact on spending growth. Results from the project have been used by HCFA's Office of the Actuary to assess the effects of various policy alternatives regarding insurance coverage and medical spending.

Status: The project has produced theoretical and empirical results regarding the impact of insurance coverage and other factors on medical spending growth. These results have been published in *Health Affairs*, Summer 1995, as a Data Watch item entitled "A Historical Analysis of Medical Spending Growth, 1960-1993." Work is continuing on a technical version of this study, and this year a paper has been submitted to an economics journal. Work on the determinants of insurance coverage is progressing.

95-004 **Evaluation of Case Classification Systems and Design of a Prospective Payment Model for Inpatient Rehabilitation**

Project No.:	500-92-0023
Period:	August 1995-April 1997
Funding:	$453,847
Award:	Delivery Order
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The Rand Corporation 1700 Main Street, P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	William Buczko, Ph.D. Office of Strategic Planning

Description: This project will evaluate the utility of functional assessment measures and the appropriateness of a patient classification system (Functional Related Groups) developed by researchers at the University of Pennsylvania Medical School for reimbursement of Medicare inpatient rehabilitation. Based on this evaluation, the contractor will construct a model of a prospective reimbursement system for inpatient rehabilitation under Medicare and simulate its effect on providers.

Status: Work on this project was completed in June 1997. The reports produced under this contract are available from NTIS. They are "A Classification System for Inpatient Rehabilitation Patients: A Review and Proposed Revisions to the Functional Independence Measure-Function Related Groups" by Grace Carter, Ph.D., et al. (NTIS accession number PB98-105992) and "A Prospective Payment System for Inpatient Rehabilitation" by Grace Carter, Ph.D., (NTIS accession number PB98-106024).

96-039 **Disenrollment and Selection Experience under the Medicare HMO Risk Program**

Project No.:	500-95-0053/02
Period:	June 1996-March 1998
Funding:	$156,630
Award:	Task Order
Principal Investigator:	Bryan Dowd
Awardee:	University of Minnesota 20 Delaware Street, SE. Minneapolis, MN 55455-0392
HCFA Project Officer:	Melvin J. Ingber, Ph.D. Office of Strategic Planning

Description: A series of analyses comparing Medicare health maintenance organization (HMO) joiners and disenrollees to beneficiaries in fee-for-service will be conducted. Among differences measured will be prior use characteristics such as hospitalization and costs; mortality; and occurrence of selected procedures after disenrollment. Methods will include logistic models for probability of joining an HMO conditioned on prior use,

and probability of an event after disenrollment. Data used are for counties with at least 1,000 HMO enrollees in the years 1993 and 1994.

Status: The final report has been drafted and has been through one round of comments. The report was being redrafted as of the end of December 1997.

93-073 **Evaluation of Medicaid-Managed Care Programs with 1915(b) Waivers**

Project No.:	500-92-0033/02
Period:	September 1993-March 1998
Funding:	$752,256
Award:	Delivery Order
Principal Investigator:	James S. Lubalin, Ph.D.
Awardee:	Research Triangle Institute 1615 M Street, NW., Suite 740 Washington, DC 20036-3209
HCFA Project Officer:	James P. Hadley Office of Strategic Planning

Description: This contract is evaluating the Medicaid managed-care initiatives implemented through 1915(b) waivers. The evaluation will provide information to HCFA and the States on the extent to which various features of the managed-care projects contribute to the ability of the Medicaid program to deliver cost-effective care to Medicaid-eligible populations. The evaluation will use interview data, studies submitted by the States as part of their waiver applications, and individual-level use and cost data to examine the cost effectiveness of the projects, as well as the access and satisfaction of enrollees in the managed-care programs relative to a fee-for-service alternative.

Status: The evaluation is examining 1915(b) programs in California, Florida, New Mexico, Ohio, Washington, New York, and Wisconsin. Case studies of these States have been completed. Analyses of use and cost data from California, Florida, New Mexico, and Ohio is under way. An interim report focusing on the case studies has been completed. A final report that focuses on the analytical findings is due to be completed in December 1998.

94-210 **Medicare Current Beneficiary Survey**

Project No.:	500-94-0016
Period:	July 1994-June 1999
Funding:	$51,528,116
Award:	Contract
Principal Investigator:	Brad Edwards
Awardee:	Westat Corporation 1650 Research Boulevard Rockville, MD 20850
HCFA Project Officer:	Frank Eppig Office of Strategic Planning

Description: The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population designed to aid HCFA's administration, monitoring and evaluation of the Medicare program. The survey is focused on health care use, cost and sources of payment. Data from the MCBS will enable HCFA to determine sources of payment for all medical services used by Medicare beneficiaries, including copayments, deductibles, and non-covered services; to develop reliable and current information on the use and cost of services not covered by Medicare (such as prescription drugs and long-term care); to ascertain all types of health insurance coverage and relate coverage to sources of payment; and to monitor the financial effects of changes in the Medicare program. Additionally, the MCBS is the only source of multi-dimensional person- based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services.

Status: The MCBS has been in the field continuously since the fall of 1991. It is currently in its 18th round of interviewing. To date, data files are available for 1991, 1992, 1993, 1994 and 1995.

96-061 **Expansion of the Medicare Current Beneficiary Survey**

Project No.:	500-94-0016M
Period:	September 1996-December 1997
Funding:	$479,999
Award:	Contract Modification
Principal Investigator:	Brad Edwards
Awardee:	Westat Corporation 1650 Research Boulevard Rockville, MD 20850
HCFA Project Officer:	Frank Eppig Office of Strategic Planning

Description: The Medicare Current Beneficiary Survey (MCBS) is a longitudinal, multipurpose survey of a representative sample of the Medicare population, with oversampling of the disabled and the very old. Both institutionalized persons and those residing in the community are included. Respondents are asked about service utilization, out-of-pocket expenses, health status, access to and satisfaction with care, and supplementary health insurance. Currently, about 16,000 Medicare beneficiaries are interviewed each fall, about 1,000 of whom are in risk-based health maintenance organizations.

Because of the continued growth of Medicare risk contracting, and the important policy issues involved, the MCBS is being expanded to incorporate more of a managed care focus. There are three facets to the expansion:

- The addition of 1,900 community sample members on a cross-sectional (one-time) basis to increase the representation of managed care enrollees.
- Addition of a limited number of questions that relate to managed care issues.
- Developmental work to improve the accuracy of service utilization reporting on the part of health maintenance organization enrollees.

Status: The 1,900 additional sample members were interviewed in the fall 1996. The additional survey questions on managed care were included in the fall 1996 round. Work on utilization reporting is underway.

95-095 **Access in Managed Care**

Project No.:	500-95-0048/02
Period:	September 1995-September 1998
Funding:	$401,389
Award:	Task Order
Principal Investigator:	Margo L. Rosenbach, Ph.D.
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Renee Mentnech Office of Strategic Planning

Description: The purpose of this project was to develop a framework for measuring access in managed care using encounter level data. This framework was then tested with actual data from the Harvard Community Health Plan in Boston.

Status: The contractor conducted a literature review and presented a proposed design at the first technical expert panel (TEP) meeting in January 1996. The design was revised and accepted by the TEP. A "lessons learned" document was drafted that describes the difficulties the principal investigators confronted in generating the rates from encounter data. A final report has been prepared and submitted to the TEP members for their review and comments. The report presents the findings from the two major components of this study. In the first component a series of Medicare performance indicators were developed. In most cases, the indicators applied to both the managed care and fee-for-services sectors, though the clinical algorithms sometimes differed. In addition, some indicators applied only to managed care, given the unique features of the managed care encounter data. In the second component of the study, the indicators were operationalized using Medicare fee-for-service data and data for Medicare beneficiaries enrolled in managed care to determine whether the indicators can in fact by implemented and are meaningful.

97-231 **Medicaid Managed Care**

Project No.:	500-93-0016/WA313
Period:	September 1997-September 1998
Award:	Task Order
Principal Investigator:	Hans Dutt
Awardee:	Data Computer Corporation of America P.O. Box 2665 Columbia, MD 21045
HCFA Project Officer:	David K. Baugh Office of Strategic Planning

Description: In recent years, there has been a rapid growth in managed care within the Medicaid population. Unlike Medicare, where much of the growth has resulted from enrollment in health maintenance organizations (HMOs) with broad based coverage, there are many types of models for managed care in Medicaid. They include traditional HMOs, prepaid health plans with varying degrees of breadth in coverage, health insuring organizations and various forms of case management, including primary care case management (PCCM). More recently, a number of State Medicaid agencies have

applied for section 1115 demonstration waivers to begin comprehensive health reform projects within their States. Increasing numbers of State Medicaid enrollees are now being covered under these new types of health plans. Research questions include:

1. What are the demographic characteristics of Medicaid enrollees in managed care?
2. How do the demographic characteristics of Medicaid enrollees in managed care differ from the characteristics of enrollees covered under fee-for-service?
3. What are the Medicaid utilization patterns for enrollees in managed care?
4. How do the utilization patterns of Medicaid enrollees in managed care differ from the utilization patterns of enrollees covered under fee-for-service? Where differences exist, do Medicaid enrollees in managed care have unmet health care needs?

Status: In progress.

IM-037 **Medicare HMO Evaluation**

Funding:	Intramural
HCFA Project Directors:	Cynthia G. Tudor, Ph.D. Center for Health Plans and Providers Melvin J. Ingber, Ph.D., Gerald F. Riley, and Jay Bae, Ph.D. Office of Strategic Planning

Description: To assess and monitor the Medicare risk program, the Office of Strategic Planning has established an ongoing health maintenance organization (HMO) evaluation program, examining a number of critical issues, including selection and savings, disenrollment patterns, the effect of managed care on costs in the fee-for-service sector ("spillover"), beneficiary satisfaction, and quality of care. This evaluation will also update the findings from an earlier study of the Medicare risk HMO program, conducted by Mathematica Policy Research, Inc. That study found that HCFA paid 5.7 percent more for HMO enrollees than would have been spent on them under fee-for-service (FFS).

Status: The findings from the analyses include the following:

- Selection and Savings: Using a risk adjustment model to predict the utilization of Medicare risk HMO joiners and disenrollees compared to beneficiaries remaining in fee-for-service, the analyses confirmed findings of favorable selection that used other methods and earlier data. The results indicated that in the year of enrollment, HMO joiners are on average lower users of medical care than the average beneficiary (about 18 percent lower). Disenrollees are higher than average users in the year after disenrollment (about 17 percent higher). The selection estimates varied greatly by county.

- Disenrollment: In 1994, the annual disenrollment rate among Medicare HMO enrollees was 14.2 percent; only 39 percent of these disenrollments went to fee-for-service. The highest disenrollment rates were among vulnerable subpopulations, including Medicaid buy-ins, Black beneficiaries, the disabled under age 65, and the very old. Disenrollment rates were highest in the first months following enrollment, and there was significant variation in disenrollment rates among plans.

- Perceptions of Care: Based on survey data collected in late, 1994, this study found no differences between HMO and FFS beneficiaries for most satisfaction measures. However, HMO enrollees were more likely than beneficiaries in FFS to be very satisfied with the costs of their care and getting care at the same location. In contrast, for every measure of the quality of doctor-patient interactions, the findings indicated that HMO enrollees were less likely than FFS beneficiaries to strongly agree with statements about the quality of care provided, including perceptions of the competency of their doctor, his/her understanding of the patient's medical history and what is wrong with the patient, and whether the doctor checks everything.

- Spillover: This analysis examined the effects over time of Medicare and commercial managed care enrollment rates on Medicare fee-for-service expenditures. The results appear inconsistent with the theory of spillover effects, which suggests that physicians change their practice patterns as HMO penetration increases. The results also showed that non-Medicare penetration rates had little effect on the level of Medicare expenditures. In addition, spillover effects appear to be stronger in low

penetration markets, with the effects declining as HMO enrollment rates rise. Finally, there seemed to be no evidence of spillover effects in mature HMO markets, rather the effect appeared to be transitory.

Selected findings have been published in "Disenrollment of Medicare Beneficiaries from HMOs," *Health Affairs*, September/October 1997, and "Perceptions of Care Among Medicare HMO Enrollees and Fee-for-Service Beneficiaries," *Health Affairs*, March/April 1998. Other papers are forthcoming. evaluation

IM-075 **Health Status of Medicare Enrollees in HMOs and in Fee-for-Service**

Funding:	Intramural
HCFA Project Director:	Gerald Riley Office of Strategic Planning

Description: Previous research has shown that Medicare beneficiaries enrolled in health maintenance organizations (HMOs) tend to be healthier than beneficiaries in fee-for-service (FFS), controlling for age and sex. Because Medicare's capitation formula, the Adjusted Average per Capita Cost (AAPCC) does not contain an explicit adjustment for health status; the AAPCC overpays HMOs on average. An analysis of the Fall 1994 Round of the Medicare Current Beneficiary Survey (MCBS) estimated that a comprehensive health status adjustment would lower the AAPCC an average of 12 percent, which would reduce HMO payments by about 11 percent [Riley G, Tudor C, Chiang Y, Ingber M. Health status of Medicare enrollees in HMOs and fee-for-service in 1994. *Health Care Financing Review*, Summer 1996] The analysis of 1994 MCBS data is being updated using the Fall 1996 Round. The Fall 1994 Round included only 860 respondents in risk-based HMOs. The Fall 1996 Round was expanded to include over 3,000 enrollees in risk-based HMOs, with oversampling in the Southern California and South Florida markets. The updated analysis will therefore have significantly more power to detect health status differences between HMO and FFS populations nationally, and will also produce separate estimates for two highly penetrated Medicare managed care markets.

Status: Work is currently underway. Results are expected in 1998.

93-077 **Community-Supported Living Arrangements Program: Process Evaluation**

Project No.:	500-92-0035/02
Period:	September 1993-June 1997
Funding:	$411,941
Award:	Delivery Order
Principal Investigator:	Brian Burwell
Awardee:	The MedStat Group 104 West Anapamu Street Santa Barbara, CA 93101
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning

Description: The Community-Supported Living Arrangements (CSLA) Program is designed to test the effectiveness of developing, under section 1930 of the Social Security Act, a continuum of care concept as an alternative to the Medicaid-funded residential services provided to individuals with mental retardation and related conditions (MR/RC) as an optional State plan service. The CSLA program serves individuals with MR/RCs who are living in the community either independently, with their families, or in homes with three or fewer other individuals receiving CSLA services. This model of care includes personal assistance; training and habilitation services necessary to assist individuals in achieving increased integration, independence, and productivity; 24-hour emergency assistance; assistive technology; adaptive technology; support services necessary to aid these individuals in participating in community activities; and other services, as approved by the Secretary of the Department of Health and Human Services. Costs related to room and board and to prevocational, vocational, and supported employment services are excluded from coverage. In accordance with the legislatively set maximum, California, Colorado, Florida, Illinois, Maryland, Michigan, Rhode Island, and Wisconsin have implemented CSLA programs. The purpose of this contract is to provide an evaluation of the CSLA program to HCFA's Center for Medicaid and State Operations and Congress for their consideration of policy options regarding the continuation and/or expansion of the Medicaid State Plan optional service. The evaluation will address five areas:

- Philosophy or goals guiding States' CSLA programs.
- Description of CSLA programs with respect to recipients, types of services received, and the cost of

such services.

- Description and discussion of quality assurance mechanisms being implemented.
- Exploration of the question of compatibility of the supported living concept with current goals and the structure of the Medicaid program.
- Exploration of the relationship between the supported living concept and the Americans with Disabilities Act.

Status: The contract was awarded on September 30, 1993. As of September 1996, the eight site visits to the participating States have been conducted. Six of the eight State case studies have been reviewed and are approved for distribution. Secondary data analysis will be conducted using data available from the participating CSLA States. A final evaluation report is expected in March 1997.

IM-004 **Information and Outcomes**

Funding:	Intramural
HCFA Project Director:	Paul W. Eggers, Ph.D. Office of Strategic Planning

Description: The annual reports are designed to produce a wide range of data and analyses regarding the end stage renal disease (ESRD) program. Many of the data in these reports emphasize trends and comparisons over time, making these reports standard reference sources illustrating changes in the nature of the Medicare ESRD population and in the pattern of treatment of this population.

Status: The most recent published report is "Health Care Financing Administration: Research Report: End Stage Renal Disease, 1992." HCFA Pub. No. 03359. Bureau of Data Management and Strategy. Washington, DC. U.S. Government Printing Office, September 1994. Complimentary copies of this report are available from HCFA, Office of Information Services, N2-14-04, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Telephone requests can be made to (410) 786-0069. The updated report, "Health Care Financing Administration: Research Report: End Stage Renal Disease" 1993-95," HCFA publication number 03393, was in press in December 1997.

97-035 Collection of Baseline Information for Evaluating Implementation of HIPAA

Project No.:	500-95-0056/04
Period:	September 1997-June 1998
Funding:	$180,642
Award:	Task Order
Principal Investigator:	Stephen H. Long
Awardee:	The Rand Corporation 1333 H Street, NW., Suite 800 Washington, DC 20005-4707
HCFA Project Officer:	Gerald F. Riley Office of Strategic Planning

Description: In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which improves access to insurance for some employer groups and individuals. The law also increases continuity of coverage by limiting, and in some cases eliminating, pre-existing condition restrictions, and other changes to strengthen the private insurance system. The Department of Health and Human Services is mandated to report the effects of HIPAA and State reform efforts to Congress. An evaluation of the effects of HIPAA on the insurance coverage of the population, on the premiums charged for the policies, and on the characteristics of insurance products available depends on a detailed understanding of the State regulatory and market context in which the Federal standards and provisions are implemented. The purpose of this project is to develop the contextual information needed for an evaluation, the methodology for maintaining the contextual database, and the design of the evaluation. HCFA has contracted with RAND and the Institute for Health Policy Solutions (IHPS) to complete the project tasks that are detailed below.

- Database review: RAND will review the strengths and weaknesses of existing databases that might be used in the HIPAA evaluation and identify key gaps in extant data. The review will focus on the following topics: coverage of each key market segment regulated by HIPAA, comparability of pre- and post-HIPAA data, and the feasibility of conducting State-specific analyses. It will cover population, employer, insurer, and policy databases.
- Literature review: RAND will review the literature on issues pertaining to HIPAA, in particular, and the more general health insurance access problems it was designed to address. The objectives of the literature review are: (1) to discuss HIPAA and issues that have arisen during its implementation; (2) to summarize the expected effects of HIPAA's

provisions; and (3) to identify important mediating factors that should be included in the contextual database.

- HIPAA database development: RAND and IHPS will build a database to evaluate and monitor HIPAA implementation. This database will depict the regulatory and, to the extent possible, the market environment in existence in each State prior to the passage of HIPAA. It will also measure regulatory actions or other steps the states have taken in their group and individual markets to comply with HIPAA requirements.
- Develop evaluation plan: RAND and IHPS will develop a plan to quantify the effects of HIPAA on the accessability and affordability of insurance in the group and individual insurance markets.

Status: The project is underway. The evaluation plan will: (1) provide hypotheses to be tested in the evaluation,
(2) define contrast groups to test the hypotheses, and
(3) identify the data sources and/or data collection procedures to measure the key outcome variables. A final report is due in July 1998.

95-003 **Evaluation of the Effectiveness of the Operation Restore Trust Demonstrations**

Project No.:	500-92-0014/06
Period:	September 1995-September 1997
Funding:	$738,062
Award:	Contract
Principal Investigator:	Robert Coulam, Ph.D., J.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Edward Norwood Office of Financial Management

Description: The purpose of this contract was to conduct an evaluation of the demonstration project, Operation Restore Trust. The Office of Inspector General, Administration on Aging, and HCFA jointly developed a model to demonstrate improved methods for investigation and prosecution of fraud and abuse in the provision of care or services under Medicare and Medicaid. The effort consolidated the talents and expertise of the staff of the partner and other Federal agencies in five designated States and will focus on home health agencies, hospices, nursing facilities, and durable medical providers. The evaluation examined whether the more concentrated effort rendered through the partnership model is effective and what impact the partnership model has on industry fraudulent behavior. The demonstration was conducted for a 2-year period, ending February 27, 1997.

Status: This project is completed and the final report has been accepted.

Theme 2: Improving Health Care Financing and Delivery Mechanisms

Growing costs in both the Medicare and Medicaid programs require that efforts continue to develop the next generation of financing and delivery systems in order to improve the efficiency and cost-effectiveness of health care. Substantial research is needed to improve current health financing systems and to develop new payment, cost containment and financing systems. Many of the past Medicare research and demonstration projects that aimed at reforming the program have concentrated on payment reform. The most notable examples have been the development of a prospective payment system for hospitals and physician payment reform efforts. However, the basic Medicare program has remained relatively unchanged for 25 years. While HCFA continues research and demonstrations to refine various aspects of Medicare, we also are performing studies to plan how the future Medicare program might be modernized to better meet the diverse and changing needs of the growing elderly and disabled populations. Increasing the efficiency and effectiveness of Medicare requires research and demonstrations that: explore alternatives to the fee-for-service system; develop, test and evaluate multiple and diverse products; and focus on the beneficiary in terms of promoting improved health status, responding to special needs, and simplifying administration.

90-070 **Ventilator Dependent Unit**

Project No.:	29-W-99401/3
Period:	July 1989-June 1998
Award:	Waiver-only Project
Principal Investigator:	Lawrence Connolly
Awardee:	Temple University Hospital 3401 N. Broad Street Philadelphia, PA 19140
HCFA Project Officer:	Michael Henesch Center for Health Plans and Providers
Mandates:	Section 429 of the Medicare Catastrophic Coverage Act of 1988

Description: This mandated demonstration, which the Act entitled "Demonstration Projects with Respect to Chronic Ventilator-Dependent Units in Hospitals," reviews the appropriateness of classifying chronic ventilator-dependent units in hospitals as described in Section 1886(d)(1)(B) of the Social Security Act. This Philadelphia site is reimbursed on a reasonable cost basis under rules established by the Tax Equity and Fiscal Responsibility Act of 1983 (TEFRA). The demonstration evaluates the cost and outcome of treating chronic ventilator-dependent patients in highly specialized ventilator rehabilitation units (VRUs) to determine whether patients treated in such units justify reclassification of the unit as a distinct part, prospective payment system-exempt units as defined by TEFRA.

Status: The initial 3-year demonstration at Temple was extended for 3 additional years.

91-075 **Developing Cost Control Policies for Medicare Outpatient Services**

Project No.:	17-C-90036/3
Period:	September 1991-December 1997
Funding:	$385,092
Award:	Cooperative Agreement
Principal Investigator:	Margaret Sulvetta
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Mark A. Krause, Ph.D. Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1986

Description: This project will provide HCFA with information to design cost control policies for care delivered in hospital outpatient departments. In particular, the information will be useful in the development of a prospective payment system for such services. The study principally addressed these questions:

- What are the average costs and the group variation of costs defining the units of service to bundle

different ranges of ancillary services?
- What are the technical implications of bundling payment for physicians' services with those of facility payment?
- What affiliation patterns do physicians have with hospitals, and is physicians' work concentrated among very few facilities?
- What proportion of the growth in outpatient expenditures is attributable to general inflation, service-specific inflation, increases in visits, increases in services per visit, or a shift in the types of services?
- How do charges, Medicare calculated costs, and resource costs (from the Center for Health Policy Studies' analysis) compare absolutely and relatively?

Status: The Urban Institute was awarded a competing continuation to complete a descriptive and a hospital impact analysis of the Ambulatory Patient Group (APG) Version 2.0 prospective payment system developed by 3M-Health Information Systems. The data used in this analysis consist of 1993 beneficiary claims for a representative beneficiary sample stratified by the size of the facility and whether the reason for the visit was procedural, medical, or ancillary only. The statistical analysis identified any atypical volumes, cost, or charge APGs and provided information regarding the grouping of unlike procedures and the impact of ancillary packaging on APG average charges and costs. Facility-level case-mix indices were calculated for various hospital types (size, urban/rural, teaching, etc.).

The impact analysis consisted of a simulation of what types of facilities may gain or lose under APGs paid on an average-cost basis and the magnitude of the gain or loss. The study utilized the 1993 outpatient department payment methodology by type of facility and compared that to the payments under the APG grouping methodology. The final report is under review.

95-210 **Evaluation of the Municipal Health Services Program**

Project No.:	500-95-0055/02
Period:	September 1995-September 1998
Funding:	$100,310
Award:	Task Order
Principal Investigator:	Rose Martinez
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Spike Duzor Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1993, Balanced Budget Act of 1997

Description: The Services Program (MHSP) is a multisite demonstration (Baltimore, Maryland; Cincinnati, Ohio; San Jose, California; and Milwaukee, Wisconsin) to improve access to primary care in underserved urban areas and to reduce the cost of health care. Since 1979 the program has undergone two previous evaluations. This current evaluation, which was required by the extension of the program mandated by the Omnibus Budget Reconciliation Act of 1993, is being conducted by Mathematica Policy Research, under a subcontract with the Urban Institute. It focuses on:

- Consideration of costs to Medicaid and other payers if the MHSP is terminated.
- Access to care, outcomes, beneficiary satisfaction.
- Utilization differences among different populations being served by the MHSP sites.

Because of the long length of this mandated demonstration, three additional questions are also being addressed:

- What can be learned from the MHSP experience about the demand for managed systems of care for the elderly.
- How critical are copay-exempted pharmacy and dental benefits for low-income elderly in encouraging enrollment in systems of care that limit choice of primary care physician.
- What is the future of community-based systems of care?

The project is being carried out primarily through case studies. Cost report data will be used and supplemented with Medicare program data.

Status: The evaluator has visited MHSP clinics in all four cities and has conducted extensive interviews with staff and demonstration participants. Cost reports have been analyzed from 1990 to 1995. These interviews and cost reports will be the bases for a comprehensive case study that will highlight the strengths of this demonstration.

This report will be available in June 1998.

The Balanced Budget Act of 1997 extended this demonstration for 3 more years (through December 31, 2000), in order to provide an orderly transition of demonstration patients into the mainstream Medicare program. The evaluator will also discuss the clinics' plans for transitioning into the Medicare program. Some of the clinics propose to use this 3-year transition phase as an opportunity to develop arrangements with Medicare managed care plans to develop a benefit package that contains limited demonstration services, i.e., drugs, dental and transportation.

IM-043 **Physician Behavioral Response to Fee Changes**

Funding:	Intramural
HCFA Project Directors:	Ann Meadow, Sc.D., Jesse M. Levy, Ph.D., and Edgar A. Peden, Ph.D. Office of Strategic Planning

Description: Using physician-level claims data, this project will investigate Medicare physician behavior in the face of fee changes, primarily those implemented under the Medicare fee schedule. Dependent variables (primarily indicators of access-related impacts) will include the physician's supply of selected categories of services, physician caseload, and Medicare participating physician/assignment rates. The dependent variables of interest concern services provided to Medicare beneficiaries, but the study will control for several important influences on physicians' practice, including private-insurance fees for physician services and beneficiaries' demand for care.

Status: Two main sources of data have been processed and will undergo final testing before multivariate analysis begins. The first file, summarizing Federal Employees Health Plan claims from Blue Cross and Blue Shield, will provide proxy measures of private-sector prices by procedure code at two geographic levels. The second file aggregates various economic control variables from the Area Resource File to the metropolitan statistical area geographic level. Two main sources of data for control variables have been augmented with additional years of data (1994 and 1995). These sources have been processed and will undergo final testing. The first file, summarizing Federal Employees Health Plan claims from Blue Cross and Blue Shield, will provide proxy measures of private-sector prices by procedure code at two geographic levels. The second file aggregates various economic control variables from the Area Resource File to the metropolitan statistical area geographic level.

IM-041 **Physician Practices' Responses to Changes in Fees**

Funding:	Intramural
HCFA Project Directors:	Edgar A. Peden, Ph.D. and Jesse M. Levy, Ph.D. Office of Strategic Planning

Description: This project is intended to support the implementation of the practice-cost relative-value units (RVUs) for Medicare by assessing the potential impact of the resulting fee changes on the total volumes of physician services (the "behavioral" response). It does this by reviewing the evidence concerning economic behavior for wage and price changes (including evidence concerning physician practices), systematizing this evidence into a model of economic behavior, and applying the results to posit physician practices' volume responses to overall fee changes. Most studies up to now have viewed these responses in a manner wherein physician practices permanently increase the volume of services to make up for lost income when fees decrease, and decrease or hold constant the volume of services when fees increase. This study considers whether such responses are strictly short-run and that volumes, after an initial response to fee changes, will revert to what their levels would have been without the fee changes.

Status: A draft paper has been produced.

97-227 **Technical Reports Related to Derivation of Relative Values for Physician Practice Expense**

Project No.: BPAX-97-003

Period:	February 1997-August 1997
Funding:	$10,000
Award:	BPA
Principal Investigator:	Daniel Dunn
Awardee:	Cambridge Health Economics Group 1030 Massachusetts Avenue Cambridge, MA 02138
HCFA Project Officer:	Jesse M. Levy, Ph.D. Office of Strategic Planning
Mandates:	P.L. 103-432, The Social Security Act Amendments of 1994

Description: The purpose of this project was to provide technical consultation to HCFA on issues related to the derivation of relative values for practice expenses. Tasks included review of computer software, development of physician time databases, and discussion of indirect costing methodological issues.

Status: This project has been completed.

94-008 Collect Malpractice Insurance Premium Rate Information

Project No.:	500-94-0039
Period:	July 1994-June 1997
Funding:	$347,892
Award:	Contract
Principal Investigator:	Karen Reilly, Sc.D.
Awardee:	Allied Technology Group, Inc. 1803 Research Boulevard Rockville, MD 20850
HCFA Project Officer:	Benson L. Dutton Office of Strategic Planning

Description: This study surveys State insurance commissioners, physician-owned malpractice insurers, physician associations, cooperatives, and physician joint underwriting associations. Premium rate data will be obtained from State insurance departments. These data are used by HCFA staff and outside contractors to update the malpractice component of the Medicare Economic Index (MEI) and to refine the malpractice component of the geographic practice cost index (GPCI) for the Medicare fee schedule (MFS). By law, HCFA is required to compute the annual rate of increase in malpractice insurance costs for use in the MEI and to periodically review and update the GPCI. Section 1848(e) of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and Section 4118 of OBRA 1990 require the Secretary of Health and Human Services to develop and update geographic adjustment factors for existing payment localities used in calculating the MFS. Project tasks also include developing methods for collecting representative premium data for the national MEI estimates and the GPCI market areas; investigating possible expansion to the survey; determining the existence, composition, and authority of any State patient compensation funds and joint underwriting associations; and linking the 1993-95 premium data collected under this survey with the 1989-92 data collected previously.

Status: Project tasks concluded thus far include: interviewing State insurance commissioners' staff to identify physician medical liability insurance companies in the State; collecting$1 million/$3 million malpractice premium rates for policies for 1993-95 from State insurance commissioners' office files, if available, and otherwise, through contacting key insurance company personnel named by the State insurance office; and identifying any sub-State coverage and pricing areas. For the last completed year, Allied Technology Group, Inc. (ATG) continued their collection tasks begun in the first 2 years. In addition they produced an options paper on alternatives for weighting data within GPCI areas and across GPCI areas to obtain a natural MEI and to link 1993-1995 premium data collected under this survey with the 1989-1992 data collected by the Urban Institute into a homogeneous file. Under a 9-month no-cost extension ATG will expand their data collection effort to include 1996 and possibly 1997 data providing sufficient funds remain in the budget. A draft final report covering data collected from 1993 through 1995 was submitted. A final report that will include tasks completed during the no-cost extension will be submitted in March 1998.

97-229 Budget Neutrality of Adjustment of Proposed 1999 Geographic Practice Cost Indexes

Project No.:	HCFA-97-0288
Period:	July 1997-December 1997
Funding:	$9,000
Award:	Purchase Order
Principal Investigator:	Gregory C. Pope
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330

	Waltham, MA 02154
HCFA Project Officer:	Benson L. Dutton Office of Strategic Planning

Description: HCFA's Office of the Actuary calculates budget neutrality rescaling factors for updating the raw unadjusted Geographic Practice Cost Indices (GPCIs) and Geographic Adjustment Factors (GAFs) created for HCFA by contractors. The GPCIs and GAFs presented in a report previously produced by the Health Economics Research, Inc. (HERI), "Second Update of the Geographic Practice Cost Index" were not rescaled for budget neutrality. HERI applied the budget neutrality adjustments developed by HCFA to the 1999 GCPI and produced revised tables of the 1999 GCPI's and GAFs by carrier and locality. HERI also produced 1998 transitional tables of GPCI and GAF's by carrier and locality, 1999 tables of statewide budget-neutral GPCIs and a comparison table of 1997 and 1999 budget neutral GAF's.

Status: Rescaled GPCIs and GAFs incorporating the budget neutrality update factors were delivered to HCFA in September 1997. There were no changes in the quarter-work GPCI for any Fee Schedule Areas (FSA). There were no changes in practice expense for 11 FSAs and an increase of 0.001 in the remaining 78 FSAs. There were increases in all areas for the malpractice GPCI. The comparison of changes between the 1997 GPCIs and 1999 GPCIs resulted in no differences for 51 of the 89 FSAs, increases in 9 FSAs and decreases in 29 FSAs.

IM-008 Malpractice Component of the Medicare Economic Index

Funding:	Intramural
HCFA Project Director:	Benson L. Dutton Office of Strategic Planning
Mandate:	Social Security Amendments of 1972

Description: Each year since 1975, HCFA has published the Medicare Economic Index (MEI), which was first mandated by Congress in the Social Security Amendments of 1972 for use in establishing reasonable charges for physician services. Since 1992, the MEI has been used as a key factor in determining the Medicare fee schedule's annual conversion factor update pursuant to Section 6102(a) of the Omnibus Budget Reconciliation Act of 1989. The MEI is developed by HCFA's Office of the Actuary in accordance with the basic methodology set forth in 42 Code of Federal Regulations 05.504(a)(3)(I) and 405.504(d) from selected components of the Consumer Price Index and the Producer Price Index, plus estimates of the annual changes in medical malpractice premiums for specific levels of coverage. HCFA's Office of Strategic Planning collects data from major medical malpractice insurers for calculating the annual malpractice component of the MEI.

Status: Data for updating the medical malpractice component of the MEI have been obtained and the results have been given to the Office of the Actuary.

95-055 Per Case Payment to Encourage Risk Management and Service Integration in the Inpatient Acute-Care Setting

Project No.:	500-92-0013/05
Period:	September 1995-September 1998
Funding:	$511,408
Award:	Delivery Order
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Mark Wynn Center for Health Plans and Providers

Description: The purpose of this project is to design a demonstration, conduct a solicitation, and provide technical assistance during the implementation of a per-case payment system. Discounted lump-sum payments based on each participating physician hospital organization's historical payment experience for all diagnosis-related groups will be made to the representative organization. The demonstration sites will be called Medicare physician-provider partnerships. The demonstration seeks to measure actual provider behavioral response, patient satisfaction, health outcomes, and overall impact on the Medicare program, given a financial risk-sharing intervention for acute Medicare Part A and Part B inpatient services. This demonstration is intended to provide important understanding about the administrative complexities, their associated costs, and other implementation issues surrounding a medical staff payment approach. This

demonstration builds on research conducted under two prior studies (500-92-0020DO07 and 18-C-90038/3) investigating alternative payment options for medical staffs that would promote efficiency and improve service delivery during acute inpatient stays.

Status: The contractor has assisted HCFA in soliciting sites for the demonstration and in providing technical assistance to the sites. Operation of the demonstration is scheduled to start in 1998.

94-111 Development of a Physician Prospective Payment System for Ambulatory Care

Project No.:	17-C-90309/5
Period:	September 1994-March 1998
Funding:	$421,451
Award:	Cooperative Agreement
Principal Investigator:	Merritt R. Marquardt
Awardee:	Minnesota Mining and Manufacturing Company St. Paul, MN 55144-1000
HCFA Project Officer:	Mark A. Krause, Ph.D. Office of Strategic Planning

Description: This project is developing a new patient classification system that can be used as a basis for a prospective payment system (PPS) for physician services. This new system will be based on a previously developed patient classification system for the facility component of outpatient services constructed by 3M-Health Information Systems. This system, called ambulatory patient groups (APGs), has been in existence since 1990 and is being employed as a payment methodology by several payers. This physician PPS analysis augments the APGs to encompass the professional as well as the facility component of ambulatory care. The classification methodology will be called physician care groups (PCGs). The development of PCGs is being based on a comprehensive analysis of the Medicare physician payment database as well as on other non-Medicare databases. This research will provide an alternative classification system for the payment of physicians that, in combination with the APGs, may provide a coordinated basis for the implementation of a PPS for both the professional and facility costs of ambulatory care.

Status: The project start was delayed until work on the APG system was completed (see Project 17-C-90057/5). Data development for this analysis has been completed.

96-079 Medicare Competitive Bidding Demonstration for Durable Medical Equipment

Project No.:	500-96-A3
Period:	October 1995-August 2003
Award:	Contract Modification
Principal Investigator:	Elaine Myers
Awardee:	Palmetto Government Benefits Administrators Post Office Box 100190 Columbia, SC 29202
HCFA Project Officers:	Herbert A. Silverman and Jeffrey Hinson Center for Health Plans and Providers

Description: This project will design, develop, and implement a demonstration project to test the feasibility of obtaining lower prices through competitive bidding for selected lines of durable medical equipment. The supply lines that will be offered for competitive bidding are: oxygen supplies and equipment, enteral nutrition, surgical dressings, urological supplies, and hospital beds. Demonstrations will be implemented in three Metropolitan Statistical Areas located in the region administered by Palmetto Government Benefits Administrators. This region encompasses 13 southeastern States. Abt Associates provided contracted research support to the carrier in its development of the project.

Status: The design activities are underway. Among the issues being addressed are: how to array the bids, establishing the cutoff bids to differentiate "preferred" from "nonpreferred" suppliers, instituting supply and service standards to assure that beneficiaries receive services to assure proper use of supplies, and the development of a payment methodology that provides incentives to beneficiaries to patronize suppliers offering lower prices. The current target for implementing a demonstration project at the first site is 1998. Projects will be implemented at the other two sites at 6-month intervals.

97-006 Demonstration Plan, Waiver Cost Estimate, and Bidder Solicitation Materials for the HCFA Demonstration of Competitive Bidding for Clinical

Laboratory Services

Project No.:	HCFA-97-0083
Period:	March 1997-October 1997
Funding:	$99,999
Award:	Purchase Order
Principal Investigator:	Thomas Hoerger, Ph.D.
Awardee:	Research Triangle Institute 1333 H Street, NW., Suite 800 Washington, DC 20005-4707
HCFA Project Officer:	Ann Meadow, Sc.D. Office of Strategic Planning

Description: This project will test the feasibility and effectiveness of establishing Medicare fees for clinical laboratory tests through a competitive bidding procedure. Fees for Medicare laboratory services have been paid under an administered fee schedule since 1986. The State-specific fee schedule is applicable to all commercial, physician, and hospital outpatient laboratories. With 1984 Medicare payments as a base, the fees have been repeatedly adjusted by legislative formula. Such administered fees do not adjust freely to market forces. Yet in recent years the laboratory industry has made important advances in computer technology and quality control. The purpose of the Demonstration of Competitive Bidding for Clinical Laboratory Services is to test a market-based fee setting method. The resulting fees are expected to better reflect economic trends and to achieve savings in Medicare laboratory expenditures.

To support HCFA in designing the demonstration, research activities under this contract include claims analysis, fact-finding, and literature reviews to understand the market structure and services patterns of the laboratory industry nationally and in two smaller areas; studies of the experience of other relevant competitive bidding arrangements; and review of available information on trends in lab fees and costs. Design activities include analyzing demonstration design options and formulating recommendations for specific structures and processes to be used in the laboratory competitive bidding demonstration. Additional activities include technical support for estimating the costs of the demonstration waiver and preparation of draft bidder solicitation materials.

Status: All deliverables have been completed. Major products are:

- Background Report on the Clinical Laboratory Industry, Final Report (June 1997) (available from the National Technical Information Service, accession number PB98-118664).
- Bid Solicitation Package, Draft Report (July 1997).
- Demonstration of Competitive Bidding for Clinical Laboratory Services: Demonstration Plan, Final Report (September 1997).
- Preliminary waiver cost estimates.

An article, "Developing Medicare Competitive Bidding: Findings from a Study of the Clinical Laboratory Industry," appears in the Fall 1997 issue of the *Health Care Financing Review.*

The Background Report documented the heterogeneity that marks firms in the clinical laboratory industry, reported on recent industry trends including consolidation and financial pressures affecting large national lab firms, described the role of physician office labs and hospital labs in Medicare service delivery, portrayed laboratory operations in the three main industry sectors (independent, hospital, and physician office labs), and surveyed recent public-sector activity in lab competitive bidding, along with providing detailed descriptions of two recent large-scale competitive bidding arrangements. The Background Report also analyzed national physician/supplier claims by procedure code to identify laboratory tests most appropriate to put up for bidding, and it presented extensive data on contrasting Medicare laboratory services markets in two States based on 100-percent Medicare claims data. The Bid Solicitation Package is a draft document supplying information necessary for bidders to respond to HCFA's bid solicitation. The Demonstration Plan discusses the basis for the contractor's recommendations on project design. It covers the following conceptual areas: scope of the demonstration, bidding process, selecting winners, reimbursement, quality assurance, and administration and monitoring.

92-210 Demonstration Project Study of On-Line Prospective Drug Utilization Review in Medicaid

Project No.:	11-C-90232/7
Period:	September 1992-September 1998
Funding:	$281,239
Award:	Cooperative Agreement
Principal	

Investigator:	Donald W. Herman
Awardee:	Iowa Department of Human Services Hoover Building, 5th Floor East 13th and Walnut Streets Des Moines, IA 50319-0114
HCFA Project Officer:	Michael Henesch Center for Health Plans and Providers
Mandates:	Omnibus Budget Reconciliation Act of 1990

Description: Inappropriate drug therapy is considered by many to be a serious problem. In the general population, it is estimated that 3-5 percent of hospital admissions result from medication toxicities. This demonstration seeks to determine the efficiency and cost-effectiveness of on-line prospective drug utilization review (OPDUR) by decreasing the number of related adverse drug reaction and inappropriate prescribing to Medicaid recipients.

The major objective of this demonstration is to determine whether pharmacies using an OPDUR system can improve patterns of drug use and reduce expenditures as compared with pharmacies who use only the drug utilization review practice currently required in State Medicaid programs.

During the demonstration, each transmitted prescription was electronically screened against the patient's central profile for drug-drug interactions, drug allergy and cross sensitivity; therapeutic overlap, age precautions, prescribing limits; compliance/noncompliance for refills; and drug-disease precautions. In addition, pharmacists in both the experimental and control groups were required to document their cognitive service activities and whether they received a message from the OPDUR system. There were 110 intervention and 113 control pharmacies.

The results of the screen are either a pass (no problem identified) or a fail (one or more problems identified). In addition to the transmission of messages related to screen failures back to the pharmacist, a central record was maintained of prescription transactions, problems identified, and action taken to resolve the problem. Though prescription criteria and a central record is maintained, control pharmacists were not informed of the results of the screen. Thus, screen failures were detected and recorded in identical fashion for both study groups, though only the experimental group pharmacists were informed of the results of the screen.

Individual level utilization and cost data were collected for patients obtaining care from both the experimental and control pharmacies. Most data was collected automatically via the on-line claims submissions and other linked Medicaid databases (e.g., hospitalizations, physician visits). In addition to the usual claim components an electronic documentation of the pharmacist intervention was directed into the electronic claims system.

Abt Associates, the independent evaluator, will use an independent software program to screen drug claims data in a simulated prospective drug utilization review environment. The program used by Abt is adaptable to data from multiple States. Iowa project researchers have identified screen failure data generated by the actual Iowa demonstration software that cannot be obtained from this independent software program.

Status: The demonstration is completed. Iowa has requested an extension through September 30, 1998, to complete certain supplemental analyses. This effort includes two major efforts: (1) a detailed examination of the effects of the Iowa OPDUR system on drug regimen-based process of care indicators; and (2) a detailed examination of the effects of the OPDUR and cognitive service intensity on drug regimen-based outcome indicators. The first effort will examine the effect as measured by particular changes in drug therapies caused by screen failures generated during the demonstration that may not be identifiable through the screener to be used by the independent evaluator. It will also examine the role of pharmacy, recipient, prescription claim, and screen failure characteristics as possible modifiers of the OPDUR treatment effect. The second effort proposes to evaluate particular screens within the Iowa software for which drug claims data have some face validity as outcome indicators.

93-033 **Drug Utilization Review Evaluation Contract**

Project No.:	500-93-0002
Period:	March 1993-March 1998
Funding:	$4,604,856
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.

Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Jay Bae, Ph.D. Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1990

Description: The purpose of this evaluation is to provide generalizable findings on the impact of retrospective and prospective drug utilization review. Data from the two demonstration States (Iowa and Washington) and information on Medicaid drug utilization review activities from other States will form the basis of the evaluation findings. Maryland and Georgia will serve as co-experimental and comparison states. To test the effects of on-line prospective drug utilization review and of paying pharmacists for cognitive services on drug problems, drug use and costs, other health services' use and costs, and access to services will be measured. In addition, surveys to pharmacists and physicians will be conducted to assess changes in the behavior related to the demonstration's interventions.

Status: The final report is due March 1998.

94-109 **Identifying Drug Therapy Inappropriateness: Determining the Validity of Drug Use Review Screening Criteria**

Project No.:	18-C-90302/3
Period:	September 1994-January 1997
Funding:	$209,428
Award:	Cooperative Agreement
Principal Investigator:	Ilene Zuckerman, Pharm.D.
Awardee:	University of Maryland at Baltimore 511 West Lombard Street Baltimore, MD 21201
HCFA Project Officer:	Kathleen Gondek, Ph.D. Office of Strategic Planning

Description: The purpose of this study was to determine if outpatient drug use review (DUR) screening identified clinically significant cases of inappropriate drug prescribing in the Medicaid program. The objectives of the study were:

- Quantify the agreement between a DUR screening of Maryland Medicaid claims data and the medical record.
- Test the hypothesis that cases of appropriate antihypertensive drug therapy are associated with lower mean blood pressures.
- Outline a method to establish standards of acceptable variation from the drug therapy inappropriateness criteria for drugs used to treat hypertension.
- Produce a manual for Medicaid DUR programs on assembling a minimal data set to permit an ongoing assessment of the usefulness of DUR screening of Medicaid claims data.

Status: The project is completed. The INDEPTH assessment of antihypertensive drug therapy inappropriateness was designed to approximate a "gold standard" measure. Medicaid hypertensive patient profiles were built from several information sources. Of the original 788 subjects identified from primary medical data record abstraction, 738 were eligible for analysis. One hundred of these subjects were labeled as "indeterminate" when they could not be classified as having either appropriate or inappropriate antihypertensive drug therapy using the INDEPTH assessment. The distinguishing feature for panelists "labeling" these subjects as having "indeterminate" appropriateness was missing data. Of the remaining 638 study subjects, nearly 25 percent were identified as having inappropriate drug therapy. The main validation feature for the INDEPTH assessment focused on blood pressure control. The group of study subjects with appropriate antihypertensive drug therapy consistently demonstrated significantly lower blood pressure readings than the group of study subjects with inappropriate antihypertensive drug therapy. The percent of "uncontrolled" blood pressure readings was shown to be significantly higher among the group of subjects identified with inappropriate drug therapy. Fifty-three distinctive computer-based decision algorithms were used to translate the 92 drug use screening criteria used in the DURSCREEN assessment. These algorithms were then used to identify drug therapy inappropriateness for the 738 study subjects using administrative data from Medicaid claims. A single instance of any criterion exception, or flag, was considered inappropriate therapy. Nearly two-thirds of all study subjects were identified as inappropriate. A total of 201 (43 percent) subjects classified by DURSCREEN as "inappropriate" failed more than one criterion. Utilization (both over- and

under-utilization) was the primary identifier for drug therapy inappropriateness. The median number of criteria elements (i.e., dose, duplication, drug-drug interaction, drug-disease contraindication, over-utilization, under-utilization) failed per subject was one.

The comparison of the DURSCREEN, with the INDEPTH assessment findings demonstrated statistically significant associations but very poor agreement (48 percent). Nine alternative DURSCREEN derivatives demonstrated varying levels of agreement, sensitivity, specificity and statistical association. These derivatives consisted of several combinations of the screening algorithms to operationally define drug therapy inappropriateness. One derivative offered a middle of the ground approach with a 61.9-percent agreement rate. This derivative defined inappropriateness as those subjects who failed at least one of the drug use screening criteria, but excluding subjects who failed only the 2/4/98 under-utilization criterion. Construction of receiver-operating-characteristic curves was used in an attempt to "improve" the statistical relationship between DURSCREEN and the INDEPTH findings. The number of DURSCREEN flags and the number of different criteria elements with flags were explored. The height and skewness of the curves provided little assistance in selecting a cutoff for maximum sensitivity and specificity of the DURSCREEN based on the number of flags. A series of multivariate models was developed using two continuous measures of blood pressure (i.e., mean systolic blood pressure and mean diastolic blood pressure) as the dependent variable. The development of each model included a single measure of the computerized DURSCREEN (the original and one of nine derivatives) and four control variables identified as clinically and statistically important in model development (age, compliance ratio, the number of antihypertensive drugs prescribed and the number of disease categories). These models were used to test the hypothesis that inappropriate antihypertensive drug therapy, identified by DURSCREEN, is associated with statistically significantly higher blood pressures than appropriate antihypertensive drug therapy. Although many of the multivariate models were statistically predictive of blood pressure, no single DURSCREEN model emerged as the best model and the explanatory variance was low. In only three models did the DURSCREEN measures show statistically significant p-values in their respective models. However, the explanatory variance was only 5 percent. Multiple regression on select DURSCREEN criteria and control variables demonstrated that individual DURSCREEN criteria did not provide statistical insight into the expressions of blood pressure assessment.

95-015 Evaluation of the Iowa Implementation of Ambulatory Patient Groups

Project No.:	500-92-0047/02
Period:	April 1995-November 1997
Funding:	$322,218
Award:	Delivery Order
Principal Investigator:	Sue Felt-Lisk
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW., Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	Joseph M. Cramer Center for Health Plans and Providers

Description: Under this contract, Mathematica designed and implemented an evaluation of the Iowa Medicaid Program outpatient prospective payment system. Iowa used the ambulatory patient group (APG) system developed by 3M-Health Information Systems. The contractor performed a preliminary evaluation of the APG system using data collected from the facilities and the State. In addition, Mathematica described the implementation of APGs in two Blue Cross/Blue Shield plans in Ohio and California. The evaluation activities consisted of a case study of Iowa's development and implementation of the APG system followed by an analysis of the project's reimbursement methodology. The purpose of the analysis was to assess the application of the APG system for potential implementation by Medicare on a national basis.

Status: The project has been completed and the final report submitted. It is being placed in the National Technical Information Service. Since the patient classification was completed in 1990, eleven payers --five Medicaid programs and six private insurers --have designed payment systems based on APGs, and six of the eleven have implemented APG-based payment systems. The evaluator looked at three operational APG systems in-depth and conducted telephone interviews with three other payers. Overall, the evaluator found that the six payers that have operational experience with APGs tailored their APG systems to their own priorities and markets, and implemented the systems without major

incident. They report success in reducing outpatient costs, where that was the immediate goal, and they believe the system encourages higher-cost facilities to reduce costs and rewards lower-cost facilities for their efficiency. Providers' views are more mixed. Though they are generally resigned to the use of APGs and report generally adequate overall payment, they view the system as complex, generally cannot calculate expected payment under APGs, and often let payers compute systems group-related claims rather than consolidating them prior to submission, as was the intent of the system. The evaluator found no evidence of much behavioral response by providers, but note that this could change once the system is implemented by a large payer such as HCFA.

94-085 **Predictors of Access and Effects of Medicare Post-Hospital Care for Beneficiaries 65 Years of Age or Over**

Project No.:	17-C-90395/3
Period:	September 1994-April 1998
Funding:	$502,614
Award:	Cooperative Agreement
Principal Investigator:	David L. Rabin, Ph.D.
Awardee:	Georgetown University Division of Community Health Studies and Family Medicine 3750 Reservoir Road, NW. Washington, DC 20007-2197
HCFA Project Officer:	Carolyn Rimes Center for Health Plans and Providers

Description: As a consequence of regulatory and legislative changes in the late 1980s, Medicare post-hospital care (PHC) has become the most rapidly growing Medicare expenditure. PHC consists of home health care, inpatient skilled nursing facility care, and rehabilitation hospital care. The growth in use, changes in eligibility requirements, and the increase in Medicare costs have raised questions about equal access and the effects of PHC use. The literature on PHC suggests two important trends. A few Medicare prospective payment inpatient hospital diagnosis-related-groups (DRG) account for most PHC, but within these DRGs, large variations exist in use. Personal health, economic, sociodemographic, and household factors, as well as area and health system characteristics, are predictive of the use of PHC despite equal access under the Medicare program. This study uses the Medicare Current Beneficiary Survey to investigate three major research objectives:

- Describe the personal, area, and health system characteristics of users and those of similar persons with unmet needs for PHC in order to assess differences by gender, race, and income class and the potential for substitution of care modes.
- Study the longitudinal effects of PHC on Medicare program costs an rehospitalization.
- Study the personal health effects associated with PHC.

Status: The awardee is working to prepare its final report.

94-086 **Acute and Long-Term Care: Use, Costs, and Consequences**

Project No.:	17-C-90323/3
Period:	September 1994-August 1997
Funding:	$595,787
Award:	Cooperative Agreement
Principal Investigator:	Korbin Liu, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Carolyn Rimes Center for Health Plans and Providers

Description: This study provided current information that will aid policymakers in developing options to better integrate acute, subacute, and long-term-care services. Data from the Medicare Current Beneficiary Survey were used to address three issues:

- Transitions among acute, subacute, and long-term care.
- Catastrophic costs resulting from the use of those services.
- Interactions between Medicare and Medicaid home health care.

The transitions analysis was designed to measure differences in the patterns of acute, subacute, and long-term-care use by the characteristics of Medicare beneficiaries, and to determine potential areas of access or quality of care problems. The cost analysis was designed to assess the cumulative risks over 3 years of

incurring catastrophic health care costs or experiencing Medicaid spenddown. The effects of the Qualified Medicare Beneficiaries program were evaluated. The home health care analysis was designed to estimate the interactions and possible overlaps between two rapidly expanding public programs that finance similar services. The relationship between home health care use and costs and the personal characteristics of Medicare beneficiaries and the characteristics of geographic areas, including Medicaid policies, were examined.

Status: The project was completed late in calendar year 1997. The project has produced a number of papers, including a report on the interaction between Medicaid and Medicare using State level date from 1988 and 1993 to assess the interrelationship between home health spending for Medicare and Medicaid. States were grouped for analytic purposes by: high Medicare/High Medicaid, high Medicare/low Medicaid, low Medicare/high Medicaid and low Medicare/low Medicaid expenditure patterns. From these categories, five States received extensive interviews regarding their experiences and patterns of home health expenditures with a concentration on the dual eligible population group. In addition, preliminary papers have been prepared, entitled: "Determinants and Costs of Medicare Postacute Care Provided by SNFs and HHAs" and "Disability Differentials in Medicare Costs." These are available from the project officer.

97-215 Design of an Integrated Post Acute Care System

Project No.:	500-96-0008/04
Period:	September 1997-September 1999
Funding:	$300,000
Award:	Task Order
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	University of Minnesota 420 Delaware Street, SE. Minneapolis, MN 55455-0392
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning

Description: HCFA intends to create an infrastructure of post acute and long term care delivery and payment systems that are better integrated and more flexible in meeting the needs of beneficiaries with chronic illnesses and disabilities. The transition from our current benefit and provider-based system to a beneficiary centered system requires several elements -- an assessment tool that can be used and shared across provider types, more flexible benefit packages. Funding based on beneficiary health and functional needs, and case management that involves formal and informal caregivers in care planning, and supports, and encourages, where appropriate, beneficiaries to direct their own care. Additional work that incorporates beneficiary preferences into outcome measures, as well as further attempts to differentiate outcomes by post acute care modality for different patient conditions, is also needed. The purpose of this project is to design several elements needed in a more integrated system--an assessment tool, potential case management models, appropriate payment systems, and outcome measures that cross settings and incorporate beneficiary preferences, with the ultimate intent of pilot testing and refining these elements in a demonstration. A second purpose of this project is to design an optional demonstration that tests the feasibility and effectiveness of creating a more integrated post acute care system.

Status: An initial meeting was held with the principal investigator in October 1997. Work has begun on developing potential case management models as well as an assessment instrument.

NURSING HOME CASE-MIX AND QUALITY DEMONSTRATION

Description: The Nursing Home Case-Mix and Quality Demonstration builds on past and current initiatives to develop improved nursing home case-mix payment and quality assurance system for the Medicare and Medicaid programs. This demonstration designed and implemented a combined Medicare and Medicaid nursing home resident classification and payment system in Kansas, Maine, Mississippi, and South Dakota. Two additional States, Texas and New York, participated in use of the Medicare payment system. (Additional information about the demonstration States is provided below.) The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource use groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The minimum data set plus (MDS+) for resident assessment is used for resident-care planning, payment classification, and

quality-monitoring systems. The project has consisted of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct care staff time across the States was 115 minutes per day per resident. The resident classification system and a Multistate Medicare/Medicaid Payment Index containing 44 groups was created. A 35-group variation was approved in January 1993 for the Medicaid portion in Mississippi and South Dakota. The variation collapses the 12 rehabilitation groups into 3 groups for Medicaid purposes. The States collected and reviewed over 4 million MDS+ documents on over 600,000 different residents assessed between September 1990 and July 1997. In developing the payment systems, the resident characteristic data and facility cost reports have been analyzed to determine the case mix of residents and patterns of service utilization. The Medicare case-mix-adjusted payment system was implemented in early 1996. The quality-monitoring information system has been tested, and 30 quality indicators are being used for monitoring facility-level and resident-level quality. In 1995 a second staff-time study was completed on Medicare portions of skilled nursing facilities using the national MDS2.0. The average staff time found in this study was 158 minutes per resident day, significantly longer than previously measured. This reflected the fact that only Medicare nursing units were sampled. The resource utilization groups, version III classification and index were updated and became effective in January 1997 for the Medicare portion of the demonstration. Prospective rates for rehabilitation services were added for Medicare. A third time study was done on Medicare units in non-demonstration States in 1997 to validate the 1995 study findings. The average nursing time on these units was 136 minutes per resident day. The 1995 and 1997 time study data will be combined for use in the first year of the national system (see the description above).

The Balanced Budget Act of 1997 established a national skilled nursing facility prospective payment system (SNF-PPS) based on the experience from this demonstration and others. Facilities in the Medicare portion of this demonstration will transition to the national system at the beginning of their individual fiscal year beginning after June 30, 1998.

89-057 **Multistate Nursing Home Case-Mix and Quality Demonstration: South Dakota**

Project No.:	11-C-99364/8
Period:	June 1989-December 1998
Funding:	$1,570,290
Award:	Cooperative Agreement
Principal Investigator:	Carol Job, R.N.
Awardee:	South Dakota Department of Social Services 700 Governors' Drive Pierre, SD 57501
HCFA Project Officer:	Elizabeth S. Cornelius Center for Health Plans and Providers

89-056 **Multistate Nursing Home Case-Mix and Quality Demonstration: Mississippi**

Project No.:	11-C-99362/4
Period:	June 1989-December 1998
Funding:	$1,572,289
Award:	Cooperative Agreement
Principal Investigator:	Jamie L. Collier
Awardee:	Office of Governor Robert E. Lee Building, Suite 801 Jackson, MS 39201
HCFA Project Officer:	Elizabeth S. Cornelius Center for Health Plans and Providers

89-055 **Multistate Nursing Home Case-Mix and Quality Demonstration: Maine**

Project No.:	11-C-99363/1
Period:	June 1989-December 1998
Funding:	$1,290,838
Award:	Cooperative Agreement
Principal Investigator:	Andrew Coburn, Ph.D.
Awardee:	Maine Department of Human Services State House Station No. 11 Augusta, ME 04333
HCFA Project Officer:	Elizabeth S. Cornelius Center for Health Plans and Providers

89-054 **Multistate Nursing Home Case-Mix and Quality Demonstration: Kansas**

Project No.:	11-C-99366/7
Period:	June 1989-December 1998

Funding:	$1,544,755
Award:	Cooperative Agreement
Principal Investigator:	Elaine Wells
Awardee:	Kansas Department of Social and Rehabilitative Service West Hall Topeka, KS 66606
HCFA Project Officer:	Elizabeth S. Cornelius Center for Health Plans and Providers

92-028 Texas Medicare Nursing Home Case-Mix and Quality Demonstration

Project No.:	95-C-90019/6
Period:	February 1992-December 1998
Funding:	$307,382
Award:	Cooperative Agreement
Principal Investigator:	Stephen Lorenzen, Ph.D.
Awardee:	Texas Department of Human Services P.O. Box 149030 (MC-E-601) Austin, TX 78714-9030
HCFA Project Officer:	Elizabeth S. Cornelius Center for Health Plans and Providers

90-019 New York Case-Mix Payment and Quality Demonstration

Project No.:	95-C-99540/2
Period:	May 1990-December 1998
Funding:	$981,718
Award:	Cooperative Agreement
Principal Investigator:	Robert W. Barnett
Awardee:	New York State Department of Health Empire State Plaza Albany, NY 12237
HCFA Project Officer:	Elizabeth S. Cornelius Center for Health Plans and Providers

94-062 Implementation of the Multistate Nursing Home Case-Mix and Quality Demonstration

Project No.:	500-94-0010
Period:	February 1994-August 1997
Funding:	$3,209,538
Award:	Contract
Principal Investigator:	Robert E. Burke, Ph.D.
Awardee:	Allied Technology Group, Inc. 1803 Research Boulevard, Suite 601 Rockville, MD 20850
HCFA Project Officer:	Elizabeth S. Cornelius Center for Health Plans and Providers

Description: This contract supports the implementation phase of the Multistate Nursing Home Case-Mix and Quality Demonstration in Kansas, Maine, Mississippi, New York, South Dakota, and Texas. This project builds on past and current initiatives with case-mix payment and quality assurance in nursing homes. The demonstration tests a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of process and outcomes adjusted for case mix. The project has had three phases: systems design and development, systems implementation and monitoring, and evaluation. The objectives of the implementation phase are as follows:

- Recruit facilities in the six demonstration States to participate in the Medicare portion.
- Develop and operate the Medicare case-mix system of the demonstration for HCFA that involves the fiscal intermediaries and the Medicare skilled nursing facility (SNF) providers.
- Conduct a staff-time measurement study to validate the resource utilization group, version III (RUG III) classification system and add a valid therapy payment component.
- Validate the quality indicators (QIs) and implement the quality monitoring system in the demonstration States through the States' nursing home survey process.
- Implement an administrative management and operational system that links distinct components of the demonstration (e.g., classification of residents, Medicare coverage determination, payment systems, outcome monitoring for quality assessment reliability).
- Implement a field auditing system that monitors States and nursing homes participating in the Medicare portion.

Status: In July 1993, implementation of the Medicaid prospective payment systems was begun, with full participation in 1994. Maine, Mississippi, Kansas, and South Dakota are beginning to routinely use the QI

reports in the survey and certification process as of October 1995, based on the pilot test report and the first nine validation visits.

In fall 1997, there are over 2,100 Medicare SNFs in the 6 demonstration States, in contrast to 1,120 in 1990. In 1997 there were over 620 Medicare providers participating in Phase III (routine and rehabilitation) of the demonstration.

The RUG III validation staff-time measurement data collection was completed in 7 States by July 1, 1995, including the minimum data set 2.0 (MDS2.0) on 1,896 residents across 77 study facilities in 7 States, not counting New York. Multiple analyses were carried out during 1995-6, with the rehabilitation (occupational, physical, and speech therapy) index added to the Medicare payment system in July 1996.

Phase III of the Medicare portion of the demonstration began at the start of providers' fiscal years beginning July 1, 1996. The prospective rates have been inflated on January 1 each year since. The rehabilitation therapies were added to the prospective payment in July 1996. The Balanced Budget Act of 1997 established a national skilled nursing facility prospective payment system (SNF-PPS) based on the experience from this demonstration and others. This SNF-PPS begins July 1, 1998, with facilities entering at the beginning of their individual fiscal years. Thus, this demonstration will end as the facilities transition to the new payment system.

94-081 **Evaluation of the Nursing Home Case-Mix and Quality Demonstration**

Project No.:	500-94-0061
Period:	September 1994-September 1999
Funding:	$2,980,219
Award:	Contract
Principal Investigator:	Robert J. Schmitz, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Edgar A. Peden, Ph.D. Office of Strategic Planning

Description: Under the Nursing Home Case-Mix and Quality (NHCMQ) Demonstration, HCFA is testing the feasibility of paying skilled nursing facilities (SNFs) for Medicare skilled nursing services on a prospective basis. Currently, SNFs are reimbursed on a retrospective basis for their reasonable costs, but as of July 1, 1998, a new prospective methodology will be implemented. A case-mix classification, called resource utilization groups, will be used to classify patients, permitting HCFA to pay facilities for each covered day of care, according to the case mix of patients residing in the facility on any given day. Though some costs will continue to be paid on a retrospective cost basis under the demonstration, the prospective rate will eventually include inpatient routine nursing costs and therapy costs. To guard against the possibility that inadequate care would be provided to patients with heavy care needs, a system of quality indicators has been developed that will be used to monitor the quality of care. The demonstration project was implemented in six States (Kansas, Maine, Mississippi, New York, South Dakota, and Texas) in the summer of 1995, with Medicare-certified facilities in these States being offered the opportunity to participate on a voluntary basis. The evaluation of this demonstration project will seek to estimate specific behavioral responses to the introduction of prospective payment and to test hypotheses about certain aspects of these responses. The principal goal of the evaluation of the NHCMQ Demonstration is the estimation of the effects of case-mix-adjusted prospective payment on the health and functioning of nursing home residents, their length of stay, and use of health care services; on the behavior of nursing facilities; and on the level and composition of Medicare expenditures.

Status: The evaluation design has been finalized and visits to a sample of demonstration facilities are underway. Current analytic activities center around sampling and data collection. Of special interest is collection of data on the provision of therapy services from both demonstration sites and comparison sites that will entail some primary data collection because the quantity and duration of therapies may not be reliably ascertained from Medicare claims data. The data collection plan is being developed pursuant to an assessment of the form in which most facilities maintain their records, and nurses are being recruited to abstract medical records. A key issue that will be analyzed is the probability of discharge or transfer changes under case-mix-adjusted prospective payment and what circumstances surround discharges or transfer from nursing facilities.

96-078 RUG III Validation for National Skilled Nursing Facility Payment System

Project No.:	500-96-0027
Period:	September 1996-March 1998
Funding:	$841,197
Award:	Contract
Principal Investigator:	Robert E. Burke, Ph.D.
Awardee:	Allied Technology Group, Inc. 1803 Research Boulevard, Suite 601 Rockville, MD 20850
HCFA Project Officer:	J. Donald Sherwood Center for Health Plans and Providers

Description: The purpose of this contract is to examine and report on the differences and similarities in practice patterns across the States by conducting additional staff time measurement studies in skilled nursing facilities (SNFs) in States identified as providing more than the average level of rehabilitation services on Medicare units, and in units identified as "subacute" Medicare providers. The study will be conducted in California, Colorado, Florida, and Maryland. A stratified sample of free-standing and hospital-based facilities will be used and will include units in both settings that are identified as subacute by a technical-expert panel representing the SNF industry, therapists, and other experts from the research community.

Status: The data collection phase started in fall 1997. This information, combined with the information from a similar staff-time measurement conducted in 1995 will form the basis for the case-mix index for the national SNF PPS.

97-214 Refining Resource Utilization Groups for a National Skilled Nursing Facility System

Project No.:	500-96-0003/05
Period:	September 1997-June 1999
Funding:	$238,917
Award:	Task Order
Principal Investigator:	Alan White
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	J. Donald Sherwood Center for Health Plans and Providers

Description: The purpose of this contract is to examine and report on possible refinements to the resource utilization groups, version III (RUG III) methodology for classification of skilled nursing facilities' (SNFs) residents based on their predicted resource consumption. This study will examine the components of another resident classification system, the Nursing Severity Index (NSI), and determine if items contained in the NSI could improve the predictability of the RUG III system. The study will be conducted using extant resident level information and facility resource use data from a sample of SNFs in 12 States.

Status: The staff time data needed for these analyses has just been received. The data are being checked and the files prepared for use in the analyses.

92-040 Validation of Nursing Home Quality Indicators

Project No.:	18-C-90090/9
Period:	July 1992-September 1997
Funding:	$990,094
Award:	Cooperative Agreement
Principal Investigator:	Susan A. Flanagan, M.P.H.
Awardee:	The MedStat Group 104 West Anapamu Street Santa Barbara, CA 93101
HCFA Project Officer:	Kay Lewandowski Office of Strategic Planning

Description: This project is a continuation of a cooperative agreement to investigate the usefulness of claims data from Medicaid and Medicare administration record systems as sources of nursing home quality-of-care measures. The previous study involved retrospective analysis of 1987 Medicaid and Medicare claims data and facility deficiency data from Michigan and Tennessee. The objective of the current project is to validate these resident-level claims-based quality of care indicators (QCI) by recomputation of the claims-based indicators for California and Georgia using data for 1990. To complete the validation process, a sample of residents in a sample of nursing homes will be drawn for these two States, and the medical records for these patients will be reviewed by a team of physicians and nurses. The results of the record review will then be compared with the findings of the QCI algorithms to test the relationship of the QCIs to cited deficiencies and adverse outcomes.

Status: The final report for this project has been received and is available through NTIS as report number: PB97-163752.

96-057 Case-Mix Adjustment for a National Home Health Prospective Payment System

Project No.:	500-96-0003/02
Period:	July 1996-April 1998
Funding:	$2,209,573
Award:	Task Order
Principal Investigator:	Henry Goldberg
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Ann Meadow, Sc.D. Office of Strategic Planning
Mandates:	Balanced Budget Act of 1997

Description: The primary focus of this study is to understand the variation that currently exists in terms of home health resource patterns and to use this information for the development of a case-mix adjustment system for a national home health prospective payment system. In this study, the Outcome and Assessment Information Set (OASIS), which has been developed for outcome-based quality assurance and improvement for Medicare home health agencies, will be examined to see whether items included in this instrument will be useful for case-mix adjustment. Detailed information, including information on resource utilization and additional items needed for case-mix adjustment not included on OASIS, is being collected from 90 agencies.

Status: Ninety agencies were recruited and trained from eight States for this project. All agencies began data collection in October 1997.

94-074 Design and Implementation of Medicare Home Health Quality Assurance Demonstration

Project No.:	500-94-0054
Period:	September 1994-May 1999
Funding:	$3,234,881
Award:	Contract
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard, Suite 706 Denver, CO 80222
HCFA Project Officer:	Armen Thoumaian, Ph.D. Office of Clinical Standards and Quality

Description: Currently, Medicare's home health survey and certification process is primarily focused on structural measures of quality. Although this process provides important information about home health care, an approach based on patient outcome measures would substantially increase the Medicare program's capacity to assess and improve patient well-being. To address this need, the Medicare home health quality demonstration will test an approach to developing outcome-oriented quality assurance and promoting continuous quality improvement in home health agencies. The demonstration is designed to serve two purposes: increase Health Care Financing Administration's capacity to assess the quality of Medicare home health care services and increase home health care agencies' ability to systematically evaluate and improve patient outcomes. The proposed quality assurance approach would complement existing home health certification and review programs and could be used with current survey and certification and peer review organization intervening care screen approaches. The study's conceptual framework for home health quality assessment is based on home health outcomes measures developed under a HCFA-funded study by the University of Colorado, entitled "Development of Outcome-Based Quality Measures in Home Health Services" (Contract No. 500-88-0054).

Status: Last year agencies received their first risk-adjusted agency outcome reports. During the past year agencies have been focusing their activities on improving care in selected areas where they did poorly in terms of their outcome reports. Early next year agencies will be receiving a second round of reports.

94-087 Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration with Other Care Settings on Patient Outcomes

Project No.:	17-C-90435/8
Period:	September 1994-December 1998
Funding:	$1,231,466

Award:	Cooperative Agreement
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 S. Colorado Blvd., Suite 706 Denver, CO 80222
HCFA Project Officer:	Ann Meadow, Sc.D. Office of Strategic Planning

Description: Home health care (HHC) is the most rapidly growing component of the Medicare budget in recent years. The rapid growth in home health use has occurred despite limited evidence about the necessary volume of HHC to achieve optimal patient outcomes and whether it substitutes for more costly institutional care. Little is known about integrating HHC with care in other settings to reduce overall health care costs. The central hypotheses of this study are that volume-outcome relationships are present in HHC for common patient conditions, that upper and lower volume thresholds exist that define the range of services most beneficial to patients, and that a strengthened physician role and better integration of HHC with other services during an episode of care can optimize patient outcomes while controlling costs. To test these hypotheses, a total of 3,600 patient records will be selected from agencies in 20 States. Trained data collectors at each agency will record patient health status and service information between HHC admission and discharge to assess patient outcomes and costs within the HHC episode. Long-term, self-reported outcomes will be assessed from telephone interview data at HHC admission and from 6-month follow ups. These primary data concerning patient status and outcomes will be combined with Medicare claims data over the episode of care to assess the relationship between service volume in HHC and in both patient outcomes and costs. Analysis of data relating to physician involvement and the sequence of use of other providers will address issues of integration with other services.

Status: Currently, participating agencies are in the process of collecting the necessary data.

95-076 Phase II Implementation of the Home Health Agency Prospective Payment Demonstration

Project No.:	500-95-0011
Period:	September 1995-September 1999
Funding:	$1,811,184
Award:	Contract
Principal Investigator:	Henry Goldberg
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	J. Donald Sherwood Center for Health Plans and Providers

Description: This contract implements and monitors Phase II of the Home Health Agency (HHA) Prospective Payment Demonstration. Under Phase II, a single payment per episode approach will be tested for Medicare-covered home health care. HHA participation is voluntary. It is expected that approximately 100 agencies in California, Florida, Illinois, Massachusetts, and Texas will participate in the demonstration. HHAs that agree to participate will be randomly assigned to either the prospective payment method or a control group that continues to be reimbursed in accordance with the current Medicare retrospective cost system. HHAs will participate in the demonstration for 3 years.

Status: Phase II recruitment began in fall 1994 under a previous contract with Abt Associates, Inc. The HHAs entered into the demonstration at the beginning of their fiscal years. Several HHAs began receiving per-episode payments in June 1994, with the majority entering the demonstration in January 1996. The episodic payment rates are prospectively set for each HHA, reflecting their previous practice and cost experience. Rates are adjusted annually. As a protection to both the HHAs and the Medicare program, there will be retrospective adjustments for sharing of gains or losses and for changes in an HHA's projected case mix. The project will run through 1998.

94-082 Evaluation of Phase II of the Home Health Agency Prospective Payment Demonstration

Project No.:	500-94-0062
Period:	September 1994-September 1999
Funding:	$3,528,408
Award:	Contract
Principal Investigator:	Barbara Phillips, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Ann Meadow, Sc.D. Office of Strategic Planning

Mandates: Omnibus Budget Reconciliation Act of 1987

Description: This contract is evaluating Phase II of the Home Health Agency Prospective Payment Demonstration. The demonstration is testing two alternative methods of paying home health agencies (HHA) on a prospective basis for services furnished under the Medicare program. The prospective payment approaches being tested include payments per visit by type of HHA visit discipline (Phase I) and payment per episode of Medicare-covered home health care (Phase II). Implementation of Phase II, which will test the per episode payment approach, is scheduled to begin in Spring 1995. HHAs that agree to participate are randomly assigned to either the prospective payment method or to a control group that continues to be reimbursed in accordance with the current Medicare retrospective cost system. HHAs will participate for 3 years. The evaluation will combine estimates of program impacts on cost, service use, access, and quality, with detailed information on how agencies actually change their behavior to produce a full understanding of what would happen if prospective payment replaced the current cost-based reimbursement system nationally. The findings will indicate not only the overall effects of the change in payment methodology, but also how the effects are likely to vary with the characteristics of agencies and patients. This information will be of great value for estimating the potential savings from a shift to prospective payment for home health care, for indicating where potential problems with quality of care might exist, and for identifying types of patients who might be at risk of restricted access to care as a result of their need for an unusually large amount of care. Because of the relatively small number of agencies participating, the use of qualitative information obtained in discussions with agencies concerning their characteristics and behavior will be essential for avoiding erroneous inferences.

Status: Preliminary findings from the evaluation based on the first 8 to 15 months of demonstration operations suggest that the per-episode group of home health agencies were able to reduce the number of visits provided during the 120-day episode period by 17 percent and the length of the episode by 14 percent. The findings, thus far, suggest that there is no impact on the use of other Medicare services.

94-096 Project Demonstrating and Evaluating Alternative Methods to Assure and Enhance the Quality of Long-Term Care Services for Persons with Developmental Disabilities through Performance-Based Contracts with Service Providers

Project No.:	11-C-90443/5
Period:	September 1994-September 1998
Funding:	$800,000
Award:	Cooperative Agreement
Principal Investigator:	Elaine J. Timmer
Awardee:	Minnesota Department of Human Services Health Care Administration 44 Lafayette Road St. Paul, MN 55155-3853
HCFA Project Officer:	Phyllis A. Nagy Center for Medicaid and State Operations

Description: The purpose of this project is to determine whether and how well the implementation of new approaches to quality assurance, with outcome-based definitions and measures of quality, will replace the input and process measures of quality and, in the process, contribute to improving the quality of life of persons with developmental disabilities. The Minnesota Department of Human Services was given Federal authority to waive necessary provisions of the Medicaid intermediate care facilities for the mentally retarded (ICF-MR) regulations to permit alternative quality assurance mechanisms in selected demonstration, residential, and support service programs. The department entered into performance-based contracts with counties and participating ICF-MR providers. These contracts specify the amount and conditions of reimbursement, requirements for monitoring and evaluation, and expected client-based outcomes. These client-based outcomes are determined by the client and by the legal representative, if any, and with the assistance of the county case manager and provider. Some desirable outcomes include enhancement of consumer choice and autonomy, employment, and integration into the community. Criteria for measuring participating agency achievement are drawn from, but not limited to, the outcome standards developed by the National Accreditation Council on Services for Persons with Developmental Disabilities; the "values experiences" of Frameworks for Accomplishment; and

the goals established in Personal Futures Plans, Essential Lifestyle, and Person-Centered planning. According to the proposed quality assurance framework, monitoring of individual outcomes is being done jointly among family members, case managers, and other members of the local review team on a quarterly basis.

Status: The award was made to Minnesota Department of Human Services on September 30, 1994. The first year of the cooperative agreement was used to further develop the demonstration. In December of 1995, the State was granted a section 1115 waiver to implement the demonstration.

Significant progress has been made toward meeting the program objectives. During the first operational year the following goals were achieved:

- Baseline data on outcome indicators, to be used for the purpose of establishing performance target for the second operational year, were established.
- Quality Enhancement Teams were developed to conduct the annual performance reviews. These teams are comprised of consumers, advocates, volunteers, and State staff.
- Training and technical assistance was provided to all parties involved in the project's implementation to ensure that they could successfully fulfill their roles in the new outcomes-based ICF/MR service delivery system.
- The first phase of the qualitative/case study review of the project's implementation was completed.

Several approaches have been taken to develop alternative means of ensuring that quality services are provided. Providers were granted variances to existing State licensing rules governing ICFs-MR, waiveıed services, semi-independent living services and day training and habilitation services; waiver to parts of the rule licensing supervised living facilities; and changes to the statute governing case management through an established reform process.

The University of Minnesota is under contract with the State to provide project participants with technical assistance and training in the following areas:

- Personal futures planning.
- Self determination.
- Organizational management and change.

Minnesota's Department of Human Services entered into a 3-year contract with the University of Minnesota Institute on Community Integration for the evaluation of the performance-based contracting demonstration project. It is central to this demonstration and its evaluation to be able to establish that the alternative quality assurance approaches improve or at least do not decrease the quality of life and services for the persons involved. This evaluation will include both process and outcome components. The process evaluation will describe and evaluate the procedures and activities undertaken to develop alternative outcome-based quality assurance programs. The process evaluation is by it nature qualitative, relying heavily on interviews with key people in the process of developing, implementing and otherwise being affected by the approaches being developed. Other qualitative data collection will include on-site direct observation and document review.

The outcome evaluation component of the demonstration is primarily a quantitative data collection activity seeking to obtain objective quantifiable measures of the products of the programs and services under the alternative assurance programs. Quantitative measures will include frequencies of different types of activities, access to, utilization and satisfaction with the services provided, ratings of changes in the content, quality and person-centeredness of service plans, nature and frequency of social relationships and so forth. Process and outcome evaluation components will be examined independently in descriptive analyses, but also inferentially to determine if any process variables (independent) may be associated with outcomes (dependent variables). A control condition will also be established. A matched group sample for comparison of demonstration and non-demonstration group outcomes will be drawn from Minnesota samples currently participating in the Minnesota Longitudinal Study and the 1992 participants in the independent assessment of Minnesota's Medicaid Home and Community Based Services waiver program

93-056 Evaluation of the Medicare Case Management Demonstrations

Project No.:	500-92-0011/02
Period:	June 1993-September 1997
Funding:	$700,846
Award:	Delivery Order
Principal	

Investigator:	Jennifer Shore
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Leslie M. Greenwald, Ph.D. Office of Strategic Planning
Mandate:	Omnibus Budget Reconciliation Act of 1990

Description: The purpose of this contract was to evaluate the three Medicare Case Management Demonstrations. These demonstrations were designed to test the appropriateness of providing case-management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. The demonstrations, which operated in three sites and focused on a number of chronic illnesses including congestive heart failure beginning in 1993, ended in late 1995. The final evaluation report analyzed the demonstration's cost-effectiveness and impacts on beneficiary outcomes and health status. More specifically, the final evaluation of the three demonstration sites used comparisons of claims data and a beneficiary participant survey to compare the relative expenditures, health outcomes, and health status/functional status of beneficiaries with the targeted chronic illnesses who received case management, to those who were randomized into a control group (and therefore received no case management interventions).

The following results were noted in the final report:

- The three demonstration projects successfully identified and enrolled populations of Medicare beneficiaries likely to have much higher than average Medicare reimbursements during the demonstration period. In all three sites, beneficiaries with chronic illnesses identified for the project in fact used far greater resources than those in the general Medicare population.

- Each project met with unexpectedly low levels of enthusiasm for the demonstration from beneficiaries and their physicians. In all three sites, recruiting volunteer beneficiaries was much more difficult than anticipated, and refusal rates were sometimes as high as 90 percent. Participation and coordination with beneficiary physicians, despite in some cases significant networking and outreach on the part of the project team, was difficult.

- Despite engendering high levels of satisfaction among the high cost, chronically ill beneficiaries who eventually participated, the projects failed to improve client self-care or health, or reduce Medicare spending. Comparisons of health status, functional status, and expenditures between the control and intervention groups showed no improvements due to the case management intervention.

Status: A final report is available through the National Technical Information Service, Accession number PB 98-103 328. The evaluation report suggested the following primary reasons for the lack of outcome and cost impacts found in these chronic illness case management demonstrations:

- Client's physicians were not involved in the interventions. The evaluation study found that case managers received little or no cooperation from client's physicians. Despite outreach on the part of the case managers, most physicians wanted little interaction with the case manager, and few opportunities for constructive rapport developed. The case managers at all three projects felt that they would have been more effective if they and the physicians had coordinated their advice to clients, and if physicians had generally supported their efforts.

- The projects did have not sufficiently focused interventions. Even among the two demonstration sites that focused specifically on congestive heart failure, there was little guidance built into the intervention on the types of activities the case managers should concentrate on, how often clients at different levels of severity should be contacted and monitored, or the content of the education provided.

- Projects lacked staff with sufficient case management expertise and specific clinical knowledge to generate the desired reductions in hospital use. The case managers in these projects, virtually all of whom were nurses, received several days of initial training to review project procedures and clinical topics, and some completed in-service training or attended seminars. This limited training may be an inadequate substitute for more

comprehensive experience/background in the specific target disease and in community-based care or case management.

- Projects had no financial incentive to reduce Medicare spending. In these projects, the case management intervention focused on providing education or arranging services, but had no target outcomes (such as holding hospital readmission rates to, for example, 30 percent) upon which manager reimbursement was based. In addition, since physicians played almost no role in these interventions, there was no incentive for more efficient use of services for the actual providers of care. If payment for the case management services delivered, or to providers of care, had been based even in part on measurable outcome targets, the projects might have monitored patient outcomes more closely and focused efforts more consistently on activities that would increase the likelihood of reducing costs.

94-108 **Miami Valley Hospital**

Project No.:	18-P-90365/5
Period:	September 1994-September 1998
Funding:	$830,395
Award:	Grant
Principal Investigator:	Joseph P. Malone, M.D.
Awardee:	Miami Valley Hospital Congestive Heart Failure Outreach One Wyoming Street Dayton, OH 45409
HCFA Project Officer:	Renee Mentnech Office of Strategic Planning

Description: Miami Valley Hospital, in cooperation with Wright State University-Miami Valley School of Nursing, is examining whether post-hospital education and intensive case management can reduce rehospitalization rates for congestive heart failure (CHF) patients. Patients admitted to the hospital with a CHF diagnosis and discharged to a home were assigned to case-management follow up or to standard post-hospital care.

Status: Recruitment of patients began in January of 1995 and ended June 30, 1997. A total of 225 patients were recruited and randomized into either a treatment or control group. Selected frequencies demonstrate that the randomization scheme was successful. A subset of patients who had been admitted between 1/1/95 and 11/30/96 were selected for preliminary analysis. Based on the preliminary data, there was no significant difference in the 90-day readmission rate between the treatment and control groups, with 28.1 percent of the control group and 23.9 percent of the treatment group readmitted. While there was no difference between the groups in the overall readmission rate, analysis of the time to readmission using survival analysis approached significance, with a p=.0536. These preliminary analyses suggest that a home intervention may delay the readmission of patients with congestive heart failure.

94-010 **Medicare Participating Heart Bypass Center Demonstration Extended Evaluation**

Project No.:	500-92-0013/03
Period:	July 1994-February 1998
Funding:	$363,318
Award:	Delivery Order
Principal Investigator:	Jerry Cromwell, Ph.D.
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Michael Hupfer Center for Health Plans and Providers

Description: The awardee's objective is to assist HCFA in the continued evaluation of a 5-year extended demonstration designed to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft surgery while maintaining high quality care. Health Economics Research, Inc. (HERI) will assist HCFA by continuing the demonstration evaluation plan established under a previous contract, by monitoring the demonstration sites, by collecting and analyzing data, and by preparing the final evaluation report. Some key questions to be addressed during the evaluation are:

- Did the demonstration result in a net cost savings to the Medicare program?
- What was the source of any volume increases at the demonstration sites?
- What aspects of a demonstration site are attractive to Medicare beneficiaries and to referring physicians?
- Was the quality of care at the demonstration sites

equivalent to that provided at the sites prior to the demonstration?

Status: HCFA negotiated with the finalists and selected four demonstration sites in January 1991. Implementation of the demonstration at three sites began in May 1991. In December 1992, HCFA expanded the demonstration to include three additional sites from among the remaining six recommended hospitals, bringing the total number of demonstration sites to seven. These additional sites began service delivery under the demonstration in May and June 1993. In spring 1994, at their request, the first four sites were allowed to continue under the demonstration for an additional 2 years. In June 1994, a new evaluation contract was awarded to extend the evaluation of the seven sites for the remainder of their participation. The final evaluation report is expected in February 1998.

95-050 Medicare Negotiated Bundled Payment Demonstrations: Design and Solicitation

Project No.:	500-92-0013/04
Period:	July 1995-June 1998
Funding:	$365,502
Award:	Task Order
Principal Investigator:	Jerry Cromwell, Ph.D.
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Center for Health Plans and Providers

Description: The awardee will assist HCFA in preparing the design and solicitation of a 3-year demonstration to test the feasibility of a negotiated all-inclusive pricing arrangement for a group of cardiovascular procedures and total joint replacement procedures at high-volume hospitals in targeted geographic areas. The awardee will assist HCFA in the formulation of the design, identification of factors for the selection of demonstration sites, development and publication of a solicitation package, and the analysis and review of respondent proposals.

Status: The geographic analysis was completed with recommendations for specific metropolitan statistical areas and multistate regions in which to target the demonstration solicitation. Preliminary drafts of the design and solicitation documentation were submitted for a mailing of a preapplication solicitation in December 1995. Based on the panel's recommendations, 152 of the preapplicants were invited to submit final applications; of these, 123 responded. Applications were reviewed during June, July and August of 1997. Those recommended by the application review panel received a further financial analysis in preparation for a report to the Administrator of HCFA. Selected sites are expected to begin the demonstration by late 1998.

94-130 Monitoring and Evaluation of the Medicare Cataract Surgery Alternate Payment Demonstration

Project No.:	500-94-0038
Period:	August 1994-October 1997
Funding:	$496,049
Award:	Contract
Principal Investigator:	Leo Reardon
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Cynthia K. Mason Center for Health Plans and Providers

Description: This contract assisted HCFA in the monitoring and evaluation of a demonstration to assess the feasibility of an all-inclusive negotiated price concept for cataract surgery. The negotiated price covering physician, facility, and intraocular lens costs for the procedure have been tested at a total of four sites in three metropolitan statistical areas. The 3-year demonstration was completed in April 1996. Participation by providers and beneficiaries at each site was completely voluntary. Some key questions addressed during the evaluation were:

- Did the demonstration result in a net cost savings to the Medicare program?
- What is the change over time in the use of services included and the use of services excluded from the bundle?
- Did the quality of care at the demonstration sites change from the care provided at the same sites prior to the demonstration?

Status: The final report was delivered in the fall of 1997. It is available at the National Technical Information Service, Accession Number PB98-106214.

95-017 Medicare Competitive Pricing Demonstrations

Project No.:	500-92-0014/05
Period:	September 1995-March 1998
Funding:	$963,550
Award:	Delivery Order
Principal Investigator:	Robert Coulam, Ph.D., J.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Ronald W. Deacon, Ph.D. Center for Health Plans and Providers

Description: Abt Associates, Inc. and its subcontractor, University of Minnesota, are assisting HCFA in the design, development, and implementation of Medicare competitive pricing demonstrations. In these demonstrations, HCFA replaces the existing fee-for-service-based health-maintenance-organization (HMO) payment system with a market-based pricing system. All competing Medicare HMOs in designated metropolitan statistical areas are asked to bid a capitation price that is required to provide a standard benefit package. The package represents the range of benefits currently being offered in the area. HCFA arrays the bids, selects a payment level, and pays all HMOs this government contribution. Payments are adjusted to reflect enrollee risk characteristics. HMOs which bid higher than the government contribution are required to charge premiums that reflect the additional cost. During a coordinated open-enrollment period, all Medicare beneficiaries in the demonstration areas receive enhanced education and information about the various HMO options available, as well as fee-for-service options. Beneficiaries are able to compare premiums, benefits, and other HMO characteristics and are able to enroll in the HMO of their choice through an open enrollment contractor. Beneficiaries may remain in the fee-for-service system.

Status: The contractor and HCFA developed criteria for demonstration site selection and a design report describing all aspects of the competitive pricing system. Technical expert panels were convened to review design work and made recommendations for implementing the demonstrations. During 1997, HCFA attempted to implement the demonstration, first in Baltimore and subsequently in the Denver Colorado area. In each case the implementation was halted by local objections. Subsequently, the Balanced Budget Act's Section 4011, placed new process requirements on the development of these demonstrations. This process is now underway.

96-010 Medicare Coordinated Open Enrollment

Project No.:	500-96-0024
Period:	September 1996-April 2000
Funding:	$459,970
Award:	Contract
Principal Investigator:	Lisa Adato
Awardee:	Benova, Inc. 1220 SW Morrison, Suite 700 Portland, OR 97205
HCFA Project Officer:	Leslie M. Greenwald, Ph.D. Office of Strategic Planning
Mandate:	Balanced Budget Act of 1997

Description: This contract is assisting HCFA in the site development and implementation of the upcoming Medicare Competitive Pricing Demonstration. The project will support the implementation of the Medicare Competitive Pricing demonstration, recently mandated in the Balanced Budget Act of 1997. Under this contract, Benova will support HCFA's Center for Health Plans and Providers develop identified sites for the project's implementation. Activities include:

- Meeting with beneficiary advocacy groups, managed care plans, and other local organizations.
- Preparing analysis of site-specific features to assist in the final planning.
- Adapting prototype beneficiary information materials to the specific features of the intended demonstration sites.

Benova will also conduct the actual implementation of the demonstration's beneficiary outreach and education functions as HCFA's third-party agent.

Status: As of Calendar Year 1997, no final sites for the Medicare Competitive Pricing Demonstration have been designated. This contract will support implementation of the first two sites (mandated for implementation in late 1998). The contract contains additional options for others sites, if exercised by HCFA.

95-018 Evaluation of the Medicare Choice

Demonstration

Project No.:	500-92-0011/06
Period:	September 1995-June 2000
Funding:	$1,591,240
Award:	Contract
Principal Investigator:	Lyle Nelson, Ph.D.
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW., Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	Renee Mentnech Office of Strategic Planning

Description: HCFA is in the process of implementing the Medicare Choice Demonstration to test the feasibility and desirability of new types of managed care plans for Medicare such as integrated delivery systems and preferred provider organizations. The purpose of this evaluation project is to provide a detailed assessment of the overall demonstration project, which looks specifically at beneficiary experiences in the demonstration, cost and use of services within the demonstration sites, and quality of care issues. The evaluation will provide some insights into whether the greater range of managed care options offered in this demonstration would be more appealing to the Medicare beneficiaries, and whether issues such as biased selection, high rates of disenrollment, and dissatisfaction exist. In addition, the evaluation project will provide continuous monitoring of the demonstration sites, including a comprehensive case study of each of the managed care plans in the demonstration. This part of the evaluation activities will focus on the implementation experience and operational feasibility of the new managed care plans, as well as how plans interact with carriers and HCFA.

Status: The contractor is in the process of conducting site visits to assess the implementation difficulties the plans have encountered. The first interim implementation report is currently being prepared. It is expected that a survey of plan enrollees and a fee-for-service comparison group will be conducted beginning in late summer 1998. The survey will focus on reasons for enrolling and disenrolling, enrollees' understanding of their plans, and the enrollees' perceptions of access, quality, and satisfaction.

97-030 **Verification of Encounter Data**

Project No.:	500-95-0050/02
Period:	September 1997-September 2002
Funding:	$4,223,952
Award:	Task Order
Principal Investigator:	Marjorie Hatzman
Awardee:	The MedStat Group Suite 400 4401 Connecticut Avenue, NW. Washington, DC 20008
HCFA Project Officer:	Renee Mentnech Office of Strategic Planning

Description: This contract is to assess and ensure that accurate and comprehensive encounter data are being reported in the Medicare Choices Demonstration.

Status: The contractor is finalizing the design report and will submit it for final approval in the beginning of January 1998. The first series of site visits will begin in the same month. It is expected that the identification of enrollees to include in the verification sample will also begin in January 1998.

95-006 **Evaluation of HMO Outlier Demonstration**

Project No.:	500-95-0047/02
Period:	September 1995-September 1998
Funding:	$449,297
Award:	Delivery Order
Principal Investigator:	Lyle Nelson, Ph.D.
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW, Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	Ronald W. Lambert Center for Health Plans and Providers

Description: The awardee will evaluate the Outlier Pool Demonstration. Under this demonstration, participating plans in the Seattle area will be paid at a rate of 97 percent of the adjusted average per capita cost, with 2 percent of the payments going into a pool. Plans with a higher-than-average incidence of high-cost cases will receive more from the pool than they paid in, and those with a lower incidence will receive less. In this evaluation, the awardee will focus on two primary tasks:

- Examine issues involved in setting up and running an outlier pool.

- Describe the distribution of costs, both of the individuals with claims exceeding the outlier threshold and the population of the plans' enrollees.

The awardee will also be responsible for taking the encounter data submitted by the plans and constructing a person-specific database. This database will be used to address the analytical issues under the second task above.

Status: Due to a delay in implementing the demonstration, work on this contract has not yet begun as of the end of December 1997.

90-023 **United Mine Workers of America Demonstration**

Project No.:	95-C-99643/3
Period:	July 1990-June 2000
Funding:	Waiver only
Award:	Cooperative Agreement
Principal Investigator:	Russell Crosby
Awardee:	UMWA Health and Retirement Funds 4455 Connecticut Avenue, NW. Washington, DC 20008
HCFA Project Officer:	Ronald W. Lambert Center for Health Plans and Providers

Description: The United Mine Workers of America Health and Retirement Funds (the Funds) is a waiver-only demonstration that has provided a risk-based Part B capitated payment for the Funds' Medicare-eligible retirees and dependents since 1990. During 1997, the Funds established Part B managed care networks in selected areas of Alabama, Pennsylvania and West Virginia. HCFA is continuing the current Part B capitation approach and implementing risk-sharing for Part A in these three areas. The new waivers also allow for direct admission to nursing homes for Funds beneficiaries. The Funds expects to encourage preventive care among its population and to substitute less expensive care for Part A whenever appropriate.

Status: The new demonstration will be conducted during the period January 1, 1997 through June 30, 2000. The new waivers have been awarded.

96-210 **Preparation and Analysis of Department of Defense and Medicare Data in Support of DoD/Medicare Subvention Demonstration**

Project No.:	500-95-0064/02
Period:	July 1996-October 1998
Funding:	$395,032
Award:	Task Order
Principal Investigator:	Grace Carter /Edward Fu
Awardee:	The Rand Corporation 1700 Main Street Santa Monica, CA 90407
HCFA Project Officer:	Dan Ermann Office of Legislation

Description: This project is being carried out by Fu Associates, Ltd., under a subcontract with the Rand Corporation. Fu Associates is merging, eligibility and claims data from Medicare and the Department of Defense (DoD) for DoD's beneficiaries with Medicare eligibility in specific geographic areas. Currently the merge extends from fiscal year 1992 through fiscal year 1994. The combined data are analyzed at the request of either agency to establish baselines for the demonstration project.

Status: As soon as sites are named for the demonstration project, the merge will be extended through fiscal year 1996, and then updated quarterly during the execution of the demonstration.

IM-073 **Department of Defense Medicare Subvention Demonstration**

Funding:	Intramural
HCFA Project Director:	Ronald W. Lambert Center for Health Plans and Providers
Mandate:	Balanced Budget of 1997

Description: Section 4015 of the Balanced Budget Act of 1997 mandated authorized a demonstration project under which the Department of Health and Human Services would reimburse the Department of Defense (DoD) from the Medicare trust fund for managed care services provided to Medicare-eligible military retirees in military treatment facilities. DoD is required to meet essentially the same requirements as other Medicare+Choice organizations. DoD will be paid a capitation rate equal to 95 percent of the amount paid to Medicare+Choice organizations, excluding amounts attributable to medical

education, disproportionate share hospital and a portion of capital-related costs. In addition, DoD may contract with Medicare+Choice plans to provide services to Medicare-eligible military beneficiaries and to receive payments from the plans for such services. The demonstration is to be conducted in no more than 6 sites during the 3-year period beginning January 1, 1998.

Status: HCFA and DoD are in the final stages of negotiating an agreement that will specify the parameters of the demonstration, including the 6 sites selected for participation.

94-131 **Randomized Controlled Trial of Primary and Consumer-Directed Care for Persons with Chronic Illnesses**

Project No.:	95-C-90467/2
Period:	September 1994-September 2001
Funding:	$345,243
Award:	Cooperative Agreement
Principal Investigator:	Gerald Eggert, Ph.D.
Awardee:	Monroe County Long Term Care Program, Inc. Suite 2250 349 West Commercial Street Piano Works East Rochester, NY 14445
HCFA Project Officer:	Carolyn Rimes Center for Health Plans and Providers

Description: This demonstration will assess differences in outcome for three treatment groups: a consumer-directed group, a case-managed service group, and a model that combines both treatment patterns. Findings will be compared with a control group that receives no additional services or benefits. Eligibility for participation is determined by residence in the community (at home or in an assisted living setting) and by Medicare coverage with a diagnosis of irreversible dementia or three or more limitations in activities of daily living. In addition, participants must be at risk for hospitalization (i.e., their participation is based on prior use of hospitals or emergency rooms).

Status: This demonstration has an approved waiver and will begin the implementation phase in January 1998.

94-016 **Development of a Risk Adjustment System under Health Reform**

Project No.:	500-92-0023/09
Period:	June 1994-November 1997
Funding:	$733,133
Award:	Delivery Order
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The Rand Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Melvin J. Ingber, Ph.D. Office of Strategic Planning

Description: This project will develop a risk-assessment and risk-adjustment system for the non-Medicare population. It proposes to combine a diagnosis-based system for grouping episodes of illness to determine a basic capitation level, prospective payment for particular episodes, and reinsurance as a risk-reducing system. A modified diagnosis group severity system will be the basis for defining types of episodes. The classification system developed at Value Health Sciences is the basis for the system. It groups diseases according to codes from the International Classification of Diseases, 9th Revision, Clinical Modification. The system could be used to assess the expected costs of health plan enrollees and to adjust payments to the plans. A theoretical model of provider behavior is to be developed as a guide to structuring a risk adjustment and reinsurance scheme. Data from Michigan Medicaid and commercial data are being analyzed.

Status: The final report was being redrafted as of the end of December 1997.

94-101 **Development of a Risk Adjustment System under Health Reform**

Project No.:	500-92-0021/05
Period:	June 1994-March 1997
Funding:	$1,028,822
Award:	Delivery Order
Principal Investigator:	Allen Dobson, Ph.D.
Awardee:	Lewin-VHI, Inc. 9302 Lee Highway, Suite 500 Fairfax, VA 22031-1214
HCFA Project	Cynthia G. Tudor, Ph.D.

Officer: Office of Strategic Planning

Description: Under this project, two previously developed risk adjustment systems were modified and combined. Payment amounts for capitated systems were originally developed for the Medicare population and are based primarily on diagnoses associated with inpatient hospital stays. Ambulatory care groups were developed from data for the population under 65 years of age and are based on diagnoses found in outpatient claims for physician services. These risk adjustment systems will be combined and calibrated on a data set representing two types of insurers: Federal employees' health benefit program data from Blue Cross/Blue Shield and Medicaid data from the State of Washington. The project also examined the utility of incorporating reinsurance and flat payments (i.e., "carve-outs") for high-cost episodes in a risk adjustment system for non-Medicare populations.

Status: A final report has been submitted. The study found that the quality of data in part determines the stability of the weights in the risk assessment model. Payment weights for the same risk assessment model differed substantially across the data sets used in the study. Finally, risk adjustment models incorporating health status measures predicted Medicare expenditures more accurately than demographic-only models.

94-122 Risk-Adjusted Payment Models for the Non-Elderly

Project No.:	18-C-90462/1
Period:	September 1994-September 1998
Funding:	$802,651
Award:	Cooperative Agreement
Principal Investigator:	Arlene Ash
Awardee:	Boston University 80 East Concord Street Boston, MA 02118
HCFA Project Officer:	Melvin J. Ingber, Ph.D. Office of Strategic Planning

Description: This project will develop a revised classification system based on the diagnostic-cost-group (DCG) model for the population under 65 years of age that would incorporate diagnoses from both inpatient and ambulatory encounters. A similar model is being developed for the Medicare population under another project (93-045). The revised DCGs classify diagnoses by clinical and future cost implications. A hierarchy of diagnoses within body systems results in the dominance of the most serious disease in each category. There may be coded multiple comorbidities across systems, however. The project will use data from several sources: CalPers (the five largest participating plans), Medicaid Statistical Information System (three States), MedStat, and data from Massachusetts State employees and dependents. The data cover 1991-1994 and include approximately 2 million covered lives.

Status: The project is in the process of estimating models and refining the final groupings.

94-124 Risk Adjustment of Payment for Mental Health and Substance Abuse

Project No.:	18-C-90314/1
Period:	October 1994-March 1998
Funding:	$1,056,690
Award:	Cooperative Agreement
Principal Investigator:	Richard G. Frank, Ph.D.
Awardee:	Harvard Medical School 25 Shattuck Street Boston, MA 02115
HCFA Project Officer:	Jay Bae, Ph.D. Office of Strategic Planning

Description: This risk-adjustment research project attempts to study the issues that arise from providing mental health and substance abuse care coverage under a capitation system. There are three main objectives of this project. One objective is to test the ability of three risk classification systems--ambulatory care groups (ACGs), diagnostic cost groups, and payment amount for capitated systems to explain variation in mental health and substance abuse (MH/SA) costs. The project will modify the existing systems to improve their ability to explain the variation in MH/SA costs. Another objective is to collect information on private-sector cost-sharing arrangements for "carve-out" providers of MH/SA benefits. Using the information, profits and losses of different arrangements will be compared. The third objective is to develop a simulation model that is based on the risk-classification systems and the private-sector cost-sharing arrangements. The project will evaluate the predictive accuracy of the hybrid simulation model for premium-setting purposes.

Status: The project has completed its data analyses using the New Hampshire Medicaid programs. Private insurance data from the William Mercer Co. have also been used to test the performance of alternative risk adjustment systems, e.g., the ACG and the Diagnostic Cost Group-Hierarchial Co-existing Conditions classification systems. Early results indicate that a modified ambulatory diagnostic group and a comorbidity model performed better, but none of the standard risk-adjustment models achieved R^2 values above 0.10. Hence, systematic selection remains a potential problem in a capitated mental health care program.

Apart from the data analyses, two theoretical papers have been produced and submitted for publication. One paper written by McGuire and Glazer deals with the concept of optimal risk adjustment that takes into account the degree of asymmetric information in the market. Another paper written by Frank, McGuire, et al. discusses the rationale for carve-outs in MH/SA care. In addition, this project has produced two descriptive papers that report the latest developments in financial risk-sharing arrangements and specific quality standards, such as access, customer service, satisfaction, staffing requirements, etc., for MH/SA care in the managed behavioral health care industry.

94-107 Alternative Health Risk Adjusters for the Medicare Risk Program

Project No.:	17-C-90366/3
Period:	September 1994-March 1998
Funding:	$501,581
Award:	Cooperative Agreement
Principal Investigator:	Sheldon Retchin, M.D.
Awardee:	Virginia Commonwealth University P.O. Box 980568 Richmond, VA 23298-0568
HCFA Project Officer:	Cynthia G. Tudor, Ph.D. Office of Strategic Planning

Description: The goal of this project is to develop a risk adjuster that is based on a history of serious disease (including cancer, heart disease or stroke) and severity of illness; the length of time since the last hospital stay; and comorbidities. The predictive power from using history of serious illness will be compared to the predictive power of two existing risk adjusters--the diagnostic-cost-group and ambulatory-care-group models. Both predictive accuracy and operational features will be compared. The study is intended to yield information on the extent to which the health risk adjusters are likely to eliminate over- or underpayment in the Medicare risk program under various assumptions about biased selection in health maintenance organizations.

Status: This study is in progress.

94-106 Evaluating Alternative Risk Adjusters for Medicare

Project No.:	17-C-90316/1
Period:	September 1994-March 1998
Funding:	$327,560
Award:	Cooperative Agreement
Principal Investigator:	Gregory C. Pope
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Office of Strategic Planning

Description: This project will use a variety of health status measures (e.g., functional limitations, chronic conditions, perceived health status) from the Medicare Current Beneficiary Survey (MCBS), along with the traditional adjusted average per capita cost factors to predict future expenditures for the purpose of risk adjustment. Alternative risk adjusters also will be evaluated. That is, the predictive accuracy of survey-based risk adjusters from the MCBS will be compared to claims-based risk adjusters that have been developed (e.g., diagnostic cost groups, ambulatory care groups, payment amount for capitated systems). This project also will examine the stability of health status risk adjusters over time.

Status: Preliminary findings indicate that survey-based health status models have three to four times the predictive power of demographic risk adjustment models in predicting future expenditures. The risk adjustment model derived from claims diagnoses has 75 percent greater predictive power than risk adjusters based on a comprehensive survey model. No single model predicts average expenditures well for all beneficiary subgroups of interest, suggesting a combined model may be appropriate. The investigators concluded that more years of data were needed to obtain stable and reliable

estimates of risk adjustment models before they can be implemented in payment systems. To this end, an additional year of data is being analyzed to examine the stability and reliability of the models. Project investigators presented preliminary findings at the 125th Annual Meeting of American Public Health Association in Indianapolis on November 11, 1997, and at the 50th Annual Meeting of the Gerontological Society of America session "Evaluating Alternative Risk Adjusters for Medicare" on November 16, 1997, in Cincinnati. A final report is expected in the spring of 1998.

96-038 Comparison of Concurrent DCG Models and Partial Capitation as Payment Alternatives for Managed Care Organizations

Project No.:	HCFA-96-0558
Period:	September 1996-October 1997
Funding:	$49,000
Award:	Purchase Order
Principal Investigator:	Gregory C. Pope
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Melvin J. Ingber, Ph.D. Office of Strategic Planning

Description: This project simulated the results of risk adjustment using 6 and 9 months of data from the Medicare 5-percent claims files. An estimate of the adjustment needed to produce the full year's data result was made.

Status: The project has been completed. This project was primarily for internal use in estimating the effort needed to conduct risk adjustment calculations.

96-211 Refinements to Medicare Diagnostic Cost Group Risk Adjustment Models

Project No.:	500-95-0048/03
Period:	September 1996-September 1998
Funding:	$114,897
Award:	Task Order
Principal Investigator:	Gregory C. Pope
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Melvin J. Ingber, Ph.D. Office of Strategic Planning

Description: A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations has been developed and subsequently improved. Because the Balanced Budget Act (BBA) mandated risk adjusters to be used for Medicare+Choice entities in year 2000, this project will further update the models with newer data (1995-1996) and will provide better adjustment for factors such as "working aged" and "institutionalized." The updated/new models will also be used to pay plans in the Choices demonstration, if feasible.

Managed Care Organizations have been paid for each enrollee based on a county rate book with adjustment factors reflecting age, gender, Medicaid enrollment and other demographic factors. Research has shown that plan enrollees are, on the average, healthier than the average fee-for-service beneficiaries on whom the demographic adjustments were based. Therefore, Medicare payments to plans have exceeded what would have been paid for these same enrollees had they remained in the fee-for-service program.

Risk adjuster models go beyond demographic information in adjusting payments. Clinical information from medical claims is used to modify payment to reflect the expected expenditures for each enrollee. The Diagnostic Cost Group (DCG) family of models is the most mature set of risk adjusters available. DCG models use demographic, diagnostic and procedure information to project expenditures and to provide adjusters that could be used to multiply the rate book amounts instead of the demographic factors currently used. Among the DCG models are the Principal Inpatient Diagnostic Cost Group model, which uses hospital data only, and the Hierarchial Co-existing Conditions model, which uses physician and outpatient information as well. It is a hospital-based model that is required for year 2000 by the BBA. Thereafter, an all-claims model should be phased in to adjust payments optimally.

Status: Refinements are underway based on work that was previously done on the under-65 population. The recalibration is underway based on the 1995-96 data.

96-058 Risk Adjustment for Medicaid Recipients with Disabilities

Project No.:	18-C-90599/9-02
Period:	August 1996-July 1998
Funding:	$50,000
Award:	Cooperative Agreement
Principal Investigator:	Richard Kronick, Ph.D.
Awardee:	University of California at San Diego 9500 Gilman Drive La Jolla, CA 92093
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning

Description: The objective of this project is to develop a diagnostically based, risk-adjusted payment system that may be used by State Medicaid programs when contracting on a capitated basis with health plans for Medicaid recipients with disabilities. The project will use data from three States (California, Georgia, and Tennessee). In addition to developing a risk adjustor payment system, the authors will identify solutions to implementation problems that States are likely to encounter.

Status: During the first year of the project, the contractor obtained Tape-to-Tape data from California, Georgia and Tennessee, created analytic files for California, Georgia, Tennessee, and began preliminary analyses. Currently, the contractor is continuing to analyze the Tape-to-Tape data, as well as working on developing a health-based payment system that is appropriate for health maintenance organizations that enroll children with special health care needs.

97-003 Analyses of Medicare and Massachusetts Medicaid Linked Data Files

Project No.:	HCFA-97-0055
Period:	January 1997-June 1997
Funding:	$2,400
Award:	Purchase Order
Principal Investigator:	Leonard Gruenberg
Awardee:	Data Chron Health Systems 763 Massachusetts Avenue Cambridge, MA 02139
HCFA Project Officer:	William D. Clark Office of Strategic Planning

Description: This small project analyzed Medicare/Medicaid linked data files and county worksheet files in the conduct of a preliminary study of State Medicaid Buy-in and Medicare utilization, costs and demographic variation. The contractor recommended avenues for additional analyses of buy-in and demographic variation that could be studied using Medicare-State Medicaid linked files related to demonstrations for Medicare and Medicaid beneficiaries.

Status: The project is completed.

94-097 Demonstration of Managed Care under Medicare Using Volume Performance Standards Organizations

Project No.:	95-C-90388/1
Period:	September 1994-March 1998
Funding:	$1,206,693
Award:	Cooperative Agreement
Principal Investigator:	Christopher P. Tompkins, Ph.D.
Awardee:	Brandeis University 415 South Street Waltham, MA 02254-9110
HCFA Project Officer:	Teresa L. DeCaro Center for Health Plans and Providers
Mandates:	Omnibus Budget Reconciliation Act of 1989

Description: The purpose of this project is to demonstrate the physician group volume performance standard (GVPS) model which creates a partial risk-sharing arrangement between participating physician-sponsored groups and HCFA under the fee-for-service (FFS) program. To participate, the group would have to meet quality and other standards, and submit case management and other clinical strategies to improve the clinical management and coordination of care for selected types of high-cost patients. Each group would operate under FFS. At the end of each year, the group's actual case-mix-adjusted performance would be compared to its per capita target, based on the group's historical experience, updated by a rate-of-growth factor. The difference between the target and actual performance would be considered Medicare savings. While the target would be based on all Medicare reimbursements per unique patient seen by the group, the bonus formula for Medicare savings would be constrained by the percent of total services actually provided by the group. This percentage is called the

patient capture ratio. A second multiplier would be a predetermined percent amount of savings that HCFA would share. Finally, the total bonus payment would be capped. Groups would be provided with profiles of their utilization to assist in meeting their targets in a clinically cogent manner. The goals of this demonstration include the following:

- Testing whether selected physician organizations can improve the efficiency and delivery of services to Medicare beneficiaries in the fee-for-service sector.
- Testing and refining reimbursement and incentive systems that reward providers for delivering care efficiently.
- Developing new techniques for using information for organizational and clinical decisionmaking (profiling) to facilitate controlling costs without sacrificing quality or access to care.
- Targeting GVPS models at selected physician group practices that could represent "best practices" and provide clinical and managerial leadership toward the objective of improved efficiency in the fee-for-service market.
- Developing and testing the feasibility of the required administrative infrastructure.

This demonstration follows research and development of the GVPS model under two prior studies (99-C-98526/1 and 17-C-90129/1).

Status: HCFA is preparing instructions for submitting applications and planning to target the project to 10 sites that offered to participate under the cooperative agreement, and to selected areas yet to be determined. The demonstration is expected to begin in early 1998 and include 3 performance years under GVPS. An article written by Christopher Tompkins, Stanley Wallack, and others, "Bringing Managed Care to Medicare's Fee-For-Service Sector," in the Summer 1997 issue of the *Health Care Financing Review*, describes the rationale for GVPS and its incentive structure.

96-081 Evaluation of Group-Specific Volume Performance Standards Demonstration

Project No.:	500-95-0048/04
Period:	September 1996-June 2001
Funding:	$1,697,773
Award:	Task Order
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Teresa L. DeCaro Center for Health Plans and Providers

Description: The purpose of this task order is to comprehensively evaluate the Group-Specific Volume Performance Standards (GVPS) Demonstration. Additionally, there is a group of tasks to provide technical support for setting sites' targets and measuring their actual performance. The goal of the demonstration is to test the feasibility of this partial-risk-bearing payment arrangement between the Health Care Financing Administration and qualifying physician-based organizations in the fee-for-service (FFS) market, whereby FFS rules apply within the context of a performance target, beneficiaries are not enrolled, and physician-sponsored organizations develop structures and processes to manage the services and cost of care received by FFS patients.

Status: In developing the final design parameters of the GVPS demonstration, simulations were conducted to analyze low and high expenditure outliers, eligibility mix changes, components of growth rates by type of service, and effects of case-mix adjustments. These analyses reveal sources of variability in growth rates, and support development of options for setting targets and calculating updates and bonus payments.

IM-069 New York Medicare Graduate Medical Education Demonstration

Funding:	Intramural
HCFA Project Director:	Joseph M. Cramer Center for Health Plans and Providers

Description: The New York Medicare Graduate Medical Education (GME) Demonstration provides incentives to reduce the size of residency training programs in New York State by providing transition funds to support the reorganization of service delivery and use of replacement personnel required by such changes. It also provides to incentives to promote primary care and the development of GME consortia. The demonstration will test whether payment incentives can successfully induce permanent reductions in GME programs. Specifically, Medicare

will make transition payments that will gradually decline to zero, by July 1, 2003, to hospitals that volunteer to reduce their resident count by 20 to 25 percent. Hospitals that agree to increase the fraction of primary care residents they train by 20 percent, or that are part of a formal consortium with coordinated GME programs, must reduce their number of residents 20 percent. All other hospitals must reduce their number of residents by 25 percent. Significant Medicare savings are anticipated.

Status: The Medicare waiver involves two distinct phases of participation. Phase I began on July 1, 1997, and includes 42 hospitals. Eighteen hospitals participate in three consortia, 12 are joint applicants, and 12 are individual hospitals. Consortia are: Buffalo Consortium with Buffalo General Hospital, Children's Hospital of Buffalo, Erie County Medical Center, Mercy Hospital, Millard Fillmore Hospital, Niagara Falls Memorial Hospital, Roswell Park Cancer Institute, and Sisters Hospital; Mount Sinai Consortium with Cabini Medical Center, Elmhurst Hospital Center, Mount Sinai Medical Center, and Queens Hospital Center; New York University Consortium with Bellevue Hospital Center, Brooklyn Hospital Center, Hospital of Joint Diseases and Orthopaedic Institute, Lennox Hill Hospital, New York Downtown Hospital, New York University Medical Center. Joint applicants are: Jacobi Medical Center and North Central Bronx Hospital; Maimonides Medical Center, Coney Island Hospital and Interfaith Medical Center; Presbyterian Hospital and New York Hospital; St. Barnabas Hospital and Lincoln Medical and Mental Health Center; Westchester County Medical Center, Sound Shore Medical Center and Mount Vernon Hospital. Individual hospital sites are: Beth Israel Medical Center, Catholic Medical Center, Harlem Hospital, Kings County Hospital Center, Long Island College Hospital, Long Island Jewish Medical Center, Metropolitan Hospital Center, Montefiore Medical Center, New York Eye and Ear Infirmary, St. Luke's-Roosevelt Hospital Center, Saint Vincent's Hospital and Medical Center of New York, Weethalle Medical and Mental Health Center.

Phase II applications are currently under review. Awards will be made in January 1998, and sites begin operating under the demonstration on July 1, 1998.

94-110 Maine Medicare Volume Performance Standard Demonstration Project

Project No.:	18-C-90401/1
Period:	September 1994-November 1997
Funding:	$341,750
Award:	Cooperative Agreement
Principal Investigator:	Robert B. Keller, M.D.
Awardee:	Maine Medical Assessment Foundation P.O. Box 4682 Augusta, ME 04330-1682
HCFA Project Officer:	Mark A. Krause, Ph.D. Office of Strategic Planning

Description: This research project was intended to assess the feasibility and value of a State-level Medicare volume performance standard (MVPS). Various observers have questioned the effectiveness of the current national volume performance standard methodology. These analysts have argued that the current MVPS program may not be accomplishing its intended goal of providing an incentive for physicians to avoid excessive increases in the volume of services they furnish to Medicare beneficiaries. The Maine Medical Assessment Foundation (MMAF), in conjunction with the Urban Institute, undertook to analyze national and State-level physician data to provide information about the volume (rate) and intensity (relative value units) of medical services provided to Medicare beneficiaries in the State of Maine. MMAF will utilize these data to create analytic files and reports on population-based utilization rates of services and the intensity of those services. Data was provided to 10 specialty study groups. This information was used by physicians to change their practice behaviors by improving the efficiency and appropriateness of the care they provide. Access and quality of care was monitored closely by an advisory committee, and all aspects and implications of the project were evaluated by the project staff and an external reviewer.

Status: The project has been discontinued. Although MMAF was successful in developing profiling methods and ways to effectively share them with practicing physicians, no effective progress was made in developing a State-level approach to the MVPS.

IM-066 Medical Savings Accounts for Medicare Beneficiaries

Funding:	Intramural

HCFA Project Director: Michael Kendix, Ph.D.
Office of Strategic Planning

Description: A Medical Savings Account (MSA) has two components--first, a catastrophic plan that covers expenditures above a fixed dollar value; second, an account held by the insured to be used to cover the first dollar amounts of expenditures. Some observers argue that MSAs will reduce the growth of expenditures on health services, by making the costs of these services more apparent to beneficiaries. Countervailing this effect is the expected disproportional tendency of beneficiaries to choose MSAs which may result in higher Medicare program expenditures, compared to Medicare spending if the same beneficiaries had remained in a fee-for-service program. The objective of this project is to simulate the effect on the Medicare program of allowing beneficiaries to choose an MSA as an alternative to fee-for-service or managed care. The study uses longitudinal data on Medicare beneficiaries from the Continuous Medicare History Sample.

Status: At the end of 1997, a research paper was nearly ready to submit for publication. Results of this project will be helpful in designing a demonstration of MSAs mandated by the Balanced Budget of 1997. This demonstration will commence in January 1999.

Theme 3: Meeting the Needs of Vulnerable Populations

An important area of HCFA's research and demonstration activity is the development of new approaches to meet the health care needs of vulnerable populations. These efforts are focused on issues of access, delivery systems, and financing. Vulnerable populations include minorities, the frail elderly, low income persons, high-risk pregnant women and their infants and children, underserved individuals (including urban inner city, rural, migrant workers, refugees, and frontier residents), as well as individuals with disabilities who require long-term care. HCFA's research related to *Theme 3* includes projects that: analyze the interactions of socioeconomic, environmental, and institutional factors that affect access to health care delivery; develop and test service systems that are responsive to special populations to ensure the best health care for vulnerable individuals; and study the financing of services provided to vulnerable populations and test alternative approaches.

82-001 **Arizona Health Care Cost Containment System**

Project No.:	11-W-00032/9
Period:	July 1982-September 1998
Award:	Waiver-only Project
Principal Investigator:	John H. Kelly
Awardee:	Arizona Health Care Cost Containment System 801 East Jefferson Phoenix, AZ 85034
HCFA Project Officer:	Joan Peterson, Ph.D. Center for Medicaid and State Operations

Description: This project is designed to test the effectiveness of establishing, under Title XIX of the Social Security Act, a Medicaid program based on competitive principles, including primary care physicians acting as gatekeepers, prepaid capitated contracts, competitive bidding, use of nominal copayments, and limited restrictions on freedom of choice. Acute-care services are provided by health plans and long-term care (LTC) services are provided through capitated contracts by the State with five Arizona counties and two private LTC contractors. In addition, capitated behavioral health services are provided to acute-care and long-term care enrollees.

Status: The Arizona Health Care Cost Containment System (AHCCCS) began operation on October 1, 1982, and initially covered only acute care services. The Arizona Long-Term Care System component was approved as part of a 5-year extension of the AHCCCS demonstration from October 1, 1988, through September 30, 1993. The phase-in of comprehensive behavioral health services began on October 1, 1990, and was completed on October 1, 1995. On January 6, 1993, HCFA granted a 1-year extension to the demonstration. On August 16, 1994, HCFA approved an additional 3-year extension of the waivers through September 30, 1997. On October 21, 1997, the demonstration was extended again, through September 30, 1998.

93-062 **Hawaii QUEST**

Project No.:	11-W-00001/9
Period:	April 1994-March 1999
Award:	Waiver-only Project
Principal Investigator:	Chuck Duarte
Awardee:	Hawaii Department of Human Services P.O. Box 339 Honolulu, HI 96809-0339
HCFA Project Officer:	Theresa Sachs Center for Medicaid and State Operations

Description: Hawaii QUEST is a statewide project that creates a public purchasing pool that arranges for health care through capitated managed care plans. Hawaii QUEST builds on Hawaii's Prepaid Health Care Act by integrating public and private programs to develop a more efficient, seamless health care delivery system for individuals previously served by three public programs: Medicaid, General Assistance, and the State Health Insurance Program. The project extends the Medicaid

eligibility income limits to 300 percent of the Federal poverty level and provides a benefit package consistent with the services currently offered under Hawaii's traditional Medicaid program, including medical, dental, and behavioral health services.

Status: On February 20, 1997, Hawaii submitted a Phase II amendment to include the aged, blind, and disabled population in Hawaii QUEST. That amendment is currently under review.

95-029 Minnesota Prepaid Medical Assistance Project Assistance Plus

Project No.:	11-W-00039/5
Period:	July 1995-June 1998
Award:	Waiver-only Project
Principal Investigator:	Mary Kennedy
Awardee:	Minnesota Department of Human Services 444 Lafayette Road St. Paul, MN 55155
HCFA Project Officer:	Amy Sobehrad Center for Medicaid and State Operations

Description: The Minnesota Prepaid Medical Assistance Project Plus (PMAP+) amended the original Minnesota Medicaid Demonstration by expanding the project in both size and scope. The PMAP demonstration enrolled all Aid to Families with Dependent Children (AFDC) eligibles, needy children, and pregnant women in eight Minnesota counties into prepaid managed care organizations. PMAP+ expanded prepaid managed care to nine additional counties and is expected to eventually be a statewide program. In addition, Medicaid eligibility was expanded on a statewide basis to include children and pregnant women up to 275 percent of the Federal poverty level who were previously covered under the State's MinnesotaCare program. PMAP+ will also implement a prepaid dental program and children's mental collaboratives, and will enroll persons with disabilities in Itasca County in PMAP+. These requested changes to the original Medicaid demonstration are part of a series of health care reform measures enacted by the State to improve health care quality and create a seamless system of care for its population. The MinnesotaCare Acts of 1992, 1993, and 1994 call for specific changes in the health care delivery and financing system, and Phase I involves the integration of low-income and uninsured programs and the expansion of managed care.

Status: HCFA's approval of PMAP+ allows the State to expand into the counties of Aitken, Cook, Koochinching, Benton, Sherburne, Stearns, St. Louis, Lake, and Carlton. There are currently approximately 160,000 enrollees in PMAP+ managed care organizations. In addition, the State's eligibility expansion has made approximately 52,000 MinnesotaCare children and pregnant women Medicaid-eligible. The State has formed County Development Teams for the central and northeast areas of the State to assure a smooth transition to managed care in each of these, as well as additional counties slated for expansion now or in the future. The State has begun preliminary planning for the children's mental health collaboratives and has awarded planning grants to 20 collaboratives serving 32 counties. On March 18, 1997, the State submitted an Amendment for Phase II of the project, which would further streamline all publicly funded health care programs in the State, as well as implement pilot projects to purchase health care services for disabled beneficiaries on a prepaid basis.

93-038 Oregon Reform Demonstration

Project No.:	11-W-00046/0
Period:	April 1993-January 1999
Funding:	Waiver-only Project
Award:	Grant
Principal Investigator:	Lynn Read
Awardee:	Oregon Department of Human Resources 500 Summer Street, NE. Salem, OR 97310
HCFA Project Officer:	Bruce R. Johnson Center for Medicaid and State Operations

Description: The Oregon Reform Demonstration is an innovative program of managed care and a restructured Medicaid benefit package covering both the Medicaid-eligible and the uninsured populations. The demonstration is scheduled to operate between February 1, 1994, and January 31, 1999. The demonstration extends Medicaid eligibility for Oregonians whose income is below the Federal poverty level, regardless of age, sex, and family status. Since the number of persons

eligible for benefits is substantially increased, Oregon is implementing two mechanisms for containing costs: prioritization of condition-specific treatments and procedures that will be included in the Medicaid benefit package, and managed-care initiatives to enhance coordination of care and provide incentives for controlling costs. Mental health and chemical dependence services were incorporated into the Oregon Health Plan (OHP) benefit package for up to 25 percent of the eligible population with the implementation of Phase II in January 1995 and added for the rest of the population in July 1997. In March 1995, Phase II eligibles, which include aged, blind, disabled, and foster-care children, were added to the OHP. Nursing facilities and home and community-based services will not be affected by the demonstration.

Status: As of December 1997, Oregon has requested a 3-year extension of the OHP demonstration, which is currently under review by the Department.

94-104 **Rhode Island RIte Care**

Project No.:	11-W-00004/1
Period:	August 1994-July 1999
Award:	Waiver-only Project
Principal Investigator:	Christine C. Ferguson
Awardee:	State of Rhode Island Department of Human Services 600 New London Avenue Cranston, RI 02920
HCFA Project Officer:	Deborah C. Van Hoven Center for Medicaid and State Operations

Description: This statewide initiative, approved in November 1993, seeks to increase access to and delivery of primary and preventive health care services for all Aid to Families with Dependent Children recipients (65,000) and to extend coverage to approximately 4,000 pregnant women and children under 8 years of age, with family incomes up to 250 percent of the Federal poverty level (FPL). RIteCare eligibles will be required to enroll in prepaid health plans contracted with the State to provide comprehensive health services. Prepaid health plans will offer medical and mental health benefits. Long-term-care services will not be provided through the plans. Plans will be required to offer participants a package of enhanced services to assist in overcoming the non-financial barriers to care, including home visits, nutrition counseling, childbirth education, parenting skills education, and smoking cessation. Pregnant women enrolled in RIteCare who lose eligibility 60 days post-partum will be offered the opportunity to enroll in an extended family-planning program for a 2-year period. RIteCare will include a cost-sharing component. Individuals with incomes of between 185 and 250 percent of the FPL (new eligibles) will be subject to cost-sharing requirements, either through premiums or copayment arrangements. Individuals with incomes of less than 185 percent of the FPL will not be subject to any cost-sharing requirements.

Status: Enrollment in this program began August 1, 1994. As of the end of December 1997, over 75,500 eligible women and children had been enrolled in managed-care plans. Of this, approximately 4,500 are included as a result of the waivers. The waiver population now includes children up to the age of 18 with family incomes up to 250 percent of the FPL.

94-080 **Tennessee TennCare**

Project No.:	11-W-00002/4
Period:	January 1994-December 1998
Award:	Waiver-only Project
Principal Investigator:	Theresa Clarke
Awardee:	Tennessee Department of Health 729 Church Street Nashville, TN 37247-6501
HCFA Project Officer:	Rose M. Hatten Center for Medicaid and State Operations

Description: TennCare is a statewide program that provides health care benefits to Medicaid beneficiaries, uninsured State residents, and those whose medical conditions make them uninsurable. Enrollment will be capped at 1,300,000. If the cap is reached, those in mandatory Medicaid coverage groups and the uninsurables will continue to be enrolled, while the currently uninsured group enrollment will be limited. All enrollees are served in capitated managed-care plans.

Status: The program began on January 1, 1994. Current enrollment is about 1.2 million. About 330,000 of these enrollees are in the uninsured and uninsurable groups. On July 1, 1996, the State implemented a carve-out

program to bring the severely and persistently mentally ill into managed care. Two behavioral health organizations cover behavioral health services for the entire TennCare population.

95-051 **Diamond State Health Plan**

Project No.:	11-W-00063/3
Period:	January 1996-January 2001
Award:	Waiver-only Project
Principal Investigator:	Kay Holmes
Awardee:	Delaware Health and Social Services 1901 North DuPont Highway New Castle, DE 19720
HCFA Project Officer:	Alisa Adamo Center for Medicaid and State Operations

Description: The Diamond State Health Plan (DSHP) is a mandatory statewide Medicaid managed-care program. Through the DSHP, the State seeks to:

- Increase access to preventive and primary care for the majority of Medicaid clients in Delaware;
- Slow down the increase in medical costs related to the Medicaid population; and to thereby
- Expand the population of people covered by the Medicaid program and provide insurance coverage for an additional 8,000 to 9,000 uninsured Delawareans.

This new expanded population will be eligible for Medicaid if they have an income at or below the Federal poverty level (FPL).

All Medicaid recipients are eligible for the program, with the exception of those receiving long-term care in institutional or home and community-based settings and those who are eligible for Medicare. Medicaid eligibles not eligible for DSHP will remain in the State's fee-for-service Medicaid. Adults and children with incomes of up to 100 percent of the FPL will also be eligible for health coverage through the DSHP.

Delaware has contracted with a health benefits manager (HBM) to facilitate and monitor member enrollment in managed-care plans. The HBM is responsible for outreach and education of potential eligibles through marketing and promotional activities. There are three statewide managed care plans participating in the program.

Status: The program was implemented on January 1, 1996, and the total enrollment as of June 1997 was approximately 66,000.

95-024 MassHealth: Massachusetts Health Reform Demonstration

Project No.:	11-W-00030/1
Period:	April 1995-April 2001
Award:	Waiver-only Project
Principal Investigator:	Bruce Bullen
Awardee:	Commonwealth of Massachusetts Division of Medical Assistance 600 Washington Street Boston, MA 02111
HCFA Project Officer:	Edward T. Hutton, Ph.D. Center for Medicaid and State Operations

Description: HCFA approved waivers for the Massachusetts Medicaid demonstration proposal entitled "MassHealth" on April 24, 1995. Under the approved demonstration Massachusetts would make comprehensive health care coverage available to approximately 740,000 individuals, including 480,000 currently eligible for coverage under the Massachusetts Medicaid program and 100,000 who will become newly eligible. The new eligibles include 160,000 uninsured poor and low-income individuals and families at risk of losing health insurance. The Commonwealth estimated that a majority of the uninsured in families with income under 200 percent of the Federal poverty level will become insured through MassHealth. The other targeted populations under the demonstration include low-income short-term unemployed, working disabled adults and disabled children, populations limited by insurance administration barriers (i.e., pre-existing condition exclusions and waiting periods), and small businesses and non-group members seeking purchasing leverage. MassHealth represents a set of strategies to improve access to health insurance and to stimulate the offering of affordable coverage. The program builds on the Commonwealth's existing managed-care program, which is made up of health maintenance organizations and a Primary Care Clinician Program, and existing State-only programs for the disabled and short-term unemployed.

The demonstration will be composed of the six strategies, which streamline eligibility for the current Medicaid program, provide health insurance for non-Medicaid-eligible disabled and the unemployed, advance existing Medicaid managed care programs, and make employer and employee subsidies available for health insurance coverage for the working poor.

Status: The State began providing services under the demonstration on July 1, 1997. Service delivery continues to be through the Primary Care Clinician Program and health maintenance organization (HMO) options that were part of the prior section 1915(b) demonstration, with the addition of HMOs developed by each of the Boston Public Health Commission and the Cambridge Public Health Commission. All strategies except for the subsidies for health coverage for the working poor have been implemented. The State is working toward implementing this strategy during July 1998. The State is also considering how to coordinate MassHealth and a Children's Health Insurance Plan (Title XXI).

95-027 **OhioCare**

Project No.:	11-W-00023/5
Period:	January 1995-December 2000
Award:	Waiver-only Project
Principal Investigator:	Barbara Edwards
Awardee:	Ohio Department of Human Services 30 East Broad Street Columbus, OH 43266-0423
HCFA Project Officer:	Rose M. Hatten Center for Medicaid and State Operations

Description: The section 1115 waiver demonstration entitled "OhioCare" was approved January 17, 1995. OhioCare is a statewide health care reform program that will expand coverage to include Ohio's uninsured population with incomes of up to 100 percent of the Federal poverty level. Ohio expects up to 500,000 additional recipients to receive Medicaid benefits under this program. Under OhioCare, the State will enroll all new eligibles and current Medicaid recipients into managed-care plans. Also, OhioCare will test the use of managed care for special health-related services currently administered by State agencies, such as the Departments of Mental Health and Drug and Alcohol Addiction Services. Demonstration waivers have been awarded for a 5-year period.

Status: The demonstration was implemented on July 1, 1996, and is currently enrolling only Medicaid eligibles. Seven counties have implemented mandatory enrollment in health maintenance organizations (HMO); another 10 counties have voluntary HMO enrollment. The expansion of coverage to the uninsured population and the use of managed care for special health-related services has been postponed. No date has been set for the implementation of those program elements.

96-008 **Oklahoma SoonerCare Demonstration**

Project No.:	11-W-00048/6
Period:	October 1995-June 2001
Award:	Waiver-only Project
Principal Investigator:	Garth Splinter
Awardee:	Oklahoma Health Care Authority 4545 N. Lincoln Boulevard Oklahoma City, OK 73105
HCFA Project Officer:	Dan McCarthy Center for Medicaid and State Operations

Description: SoonerCare fosters the creation of a managed-care infrastructure in urban and rural areas, thus increasing access to primary care for beneficiaries throughout the State and allowing for greater financial predictability of the State Medicaid program. SoonerCare uses fully capitated delivery systems in urban areas and requires urban plans to be "rural partners" by expanding their provider networks into adjacent rural areas. The urban health plan/rural partner program was implemented July 1, 1996, and 73,226 Aid to Families with Dependent Children (AFDC) and AFDC-related beneficiaries are currently enrolled. In rural areas without managed care organizations, a partially capitated primary care physician/case management (PCP/CM) model is used. The PCP/CM program was piloted in a tri-county area beginning April 1, 1996 and was implemented statewide on October 1, 1996. The PCP/CM program currently serves 51,907 beneficiaries. This includes AFDC and AFDC-related populations, as well as beneficiaries who are aged, blind, and disabled (ABD) for primary care services only. The State plans to implement the program

for the entire non-institutionalized ABD population July 1, 1997.

Status: Implementation began April 1, 1996.

95-021 **Vermont Health Access Plan**

Project No.:	11-W-00051/1
Period:	August 1995-July 2001
Award:	Waiver-only Project
Principal Investigator:	Cornelius D. Hogan
Awardee:	Vermont Agency of Human Services 103 South Main Street Waterbury, VT 05671
HCFA Project Officer:	Jane Forman Center for Medicaid and State Operations

Description: Vermont's section 1115 Medicaid demonstration proposal, entitled "Vermont Health Access Plan" (VHAP), will make comprehensive health care coverage available to approximately 90,500 individuals, including 64,000 individuals currently eligible for coverage under Vermont's Medicaid program, and 26,500 uninsured poor who will become newly eligible. VHAP will implement a statewide mandatory Medicaid managed-care program. The program began on January 1, 1996, and will operate for 5 years. The demonstration will provide health care services to uninsured lower-income Vermonters (up to 150 percent of the Federal poverty level [FPL]); provide a Medicaid prescription-drug benefit to the State's lower-income Medicare beneficiaries (up to 150 percent of the FPL); and improve access, service coordination, and quality of care through the implementation of a managed-care delivery system.

Status: Vermont was able to implement the managed care program in March of 1997. The State is planning to include the Supplemental Security Income population in mid-1998.

94-105 **Extension of Medicaid Benefits for Post-Partum Women**

Project No.:	11-W-00007/4
Period:	January 1994-February 1998
Award:	Waiver-only Project
Principal Investigator:	Gwen Power
Awardee:	South Carolina Department of Health P.O. Box 8206 Columbia, SC 29202-8206
HCFA Project Officer:	Edward T. Hutton, Ph.D. Center for Medicaid and State Operations

Description: South Carolina's Extension of Medicaid Benefits for Post-Partum Women seeks to increase the amount of time between pregnancies by extending and expanding family planning services to post-partum women. Under current law, if a woman is eligible for Medicaid only because of her pregnancy (i.e., her income is otherwise too high), Medicaid family planning benefits continue for 60 days after giving birth. Initially in this project, South Carolina extended coverage for an additional 22 months for post-partum women. Women whose family income is at or below 185 percent of the Federal poverty level (FPL) at the time of giving birth are eligible for a defined set of family planning services during the additional 22-month period, without regard to subsequent changes in income level. The project targeted providing services to approximately 20,000 women a year. The demonstration project, however, has been amended to extend coverage for family planning services to all women with incomes up to 185 percent of the FPL for the duration of the demonstration. Services are not to be limited to post-partum women or for only 22 months. South Carolina will evaluate the project by using State vital records and Medicaid Management Information Systems data to do trend analyses within comparable populations to measure the effect of the demonstration. Measures will include pregnancies averted or postponed and improvement in birth outcomes (e.g., reductions in premature births, low birth weight, neonatal intensive care unit cases).

Status: The demonstration was awarded December 1993 and began providing services July 1994. The amendment to extend demonstration eligibility to all women with income up to 185 percent of the FPL was awarded January 1997 and the amendment was implemented June 1997. During the spring of 1997, demonstration services were provided to 11,450 women. An additional 40,000 women are targeted under the amendment.

98-201 **ARKids First**

Project No.:	11-W-00115/6
Period:	September 1997-August 2002
Award:	Waiver-only Project
Principal Investigator:	Ray Hanley
Awardee:	Arkansas Department of Human Services Division of Medical Services Donaghey Plaza South P.O. Box 1437 Little Rock, AR 72203-1437
HCFA Project Officer:	Joan Peterson, Ph.D. Center for Medicaid and State Operations

Description: The ARKids First program expands eligibility to currently uninsured children through age 18 with family income at or below 200 percent of the Federal poverty level. The expansion will cover approximately 37,000 children in the first year of the program, increasing to almost 52,000 in the fifth year. The objectives of the demonstration are to integrate uninsured children into the health care delivery system and to provide benefits comparable to the State Employees and State Teachers insurance program. Arkansas' existing section 1915(b) waiver program, ConnectCare, will continue to operate as a separate program, enrolling applicants who meet current Medicaid eligibility requirements. ARKids First operates as a fee-for-service, primary care case management model. It employs the ConnectCare provider network currently in place for the section 1915(b) program.

Status: This demonstration was implemented on September 1, 1997.

96-045 The Alabama BAY (Better Access For You) Health Plan Demonstration Project for Mobile County

Project No.:	11-W-00085/4
Period:	December 1996-September 2002
Award:	Waiver-only Project
Principal Investigator:	Gwendolyn H. Williams
Awardee:	Alabama Medicaid Agency 501 Dexter Avenue Montgomery, AL 36103-5624
HCFA Project Officer:	Maria Boulmetis Center for Medicaid and State Operations

Description: The State of Alabama has set up a managed care delivery system in Mobile County composed of a private-public partnership that will enroll all Medicaid beneficiaries into a managed care network, which is called the BAY Health Network. The network is administered by the PrimeHealth Organization, a health maintenance organization (HMO) based in Mobile. Those eligible to participate under the demonstration are current Medicaid eligibles which include Aid to Families with Dependent Children (AFDC), low-income children, low-income adults, infants of Supplemental Security Income (SSI) mothers, Aged, Blind, Disabled. There will be an extension of family planning benefits of up to 24 months for post-partum women below 133 percent of poverty. All eligibles except low income pregnant women (who are receiving care under a section 1915 waiver program) will be guaranteed 6 months of Medicaid eligibility for HMO-covered services only. The benefit package will be the current mandated Medicaid benefits. The provider network will consist of the traditional Medicaid providers, but there will be opportunities for any willing provider to participate within the network if they meet the credential requirements specified within the managed care contract. Beneficiaries may change providers within the network at any time and without cause, except in cases of documented abuse. There will be no cost sharing for Medicaid beneficiaries under the demonstration.

Status: The State implemented the demonstration on May 1, 1997, for the AFDC-related Medicaid population. Enrollment for the SSI is scheduled to begin in early 1998.

96-006 Illinois MediPlan Plus Demonstration

Project No.:	11-W-00091/5
Period:	July 1996-July 2001
Award:	Waiver-only Project
Principal Investigator:	George Hovanec
Awardee:	Illinois Department of Public Aid Jesse B. Harris Building Springfield, IL 62762-0001
HCFA Project Officer:	Gina P. Clemons Center for Medicaid and State Operations

Description: The goal of this demonstration is to increase access and quality of health care for the State's 1.1 million Medicaid beneficiaries and limit rising costs through the increased use of managed care. Illinois intends to contract with a mix of health maintenance organizations (HMO), managed care community networks (MCCNs), and enrolled managed-care providers that incorporate federally qualified health centers, rural health clinics, and physicians who agree to provide primary care case management services. In addition, as a transition to managed care, for a limited period, community providers who are interested in forming an MCCN will be permitted to participate as a Prepaid Health Plan in order to gain incremental experience in operating a managed care delivery system. MediPlan Plus will be implemented statewide. In areas where MCCN access exists to serve beneficiaries, the State will be given a waiver of freedom-of-choice and exemptions from the HMO lock-in provisions and the 75/25 enrollment composition provision. In areas where there is not sufficient MCCN access, only the waivers permissible through the section 1915(b) program (freedom-of-choice) will be granted.

Status: The State is conducting pre-implementation activities.

96-007 **Medicaid Demonstration Project for Los Angeles County**

Project No.:	11-W-00076/9
Period:	July 1996-June 2000
Award:	Waiver-only Project
Principal Investigator:	Joe Kelly
Awardee:	State of California 714/744 P Street Sacramento, CA 4234-7320
HCFA Project Officer:	Gina P. Clemons Center for Medicaid and State Operations

Description: This 5-year, budget-neutral demonstration will provide fiscal relief to the County, stabilize the public health system, and assist the process of restructuring the County's health care delivery system to rely more on primary and outpatient care. It will implement the agreement reached in September 1995 with State and County officials, and is the result of a partnership effort by Federal, State, and county governments.

Status: As required in the special terms and conditions, the State and County are in the process of finalizing a detailed plan for restructuring (the Project Management Plan). This plan provides specific and measurable goals, milestones, time lines, and cost estimates. When approved, the Project Management Plan will serve as the guiding document for the programmatic aspects of the demonstration.

93-079 **Demonstration Project for Preventive and Primary Pediatric Care: Maryland**

Project No.:	11-W-00003/3
Period:	October 1993-September 1998
Award:	Waiver-only Project
Principal Investigator:	Joseph M. Millstone
Awardee:	Maryland Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201
HCFA Project Officer:	Gina P. Clemons Center for Medicaid and State Operations

Description: Waivers were approved for a 5-year period, beginning October 1, 1993, to cover children under Medicaid who meet the following criteria:

- Born after September 30, 1993.
- Between 1 and 19 years of age; not currently eligible for the Medicaid program.
- Living in families whose income does not exceed 185 percent of the Federal poverty level, with no resource limitation.

Maryland intends to demonstrate that access to basic primary care and preventive services increases the utilization of such services, improves health outcomes, and is cost effective by preventing acute and chronic medical conditions. No hospital inpatient, outpatient, or emergency-room services are provided.

Status: The demonstration is in the final year of operation. Enrollment continues to be lower then expected. As of March 1997, there were approximately 5,000 children enrolled in the project, compared to a projected 21,000 the State anticipated would be enrolled

by the end of September 1997.

96-009 **Maryland Medicaid Section 1115 Health Care Reform Demonstration Proposal--HealthChoice**

Project No.:	11-W-00099/3
Period:	October 1996-April 2002
Award:	Waiver-only Project
Principal Investigator:	Barbara Shipnuck
Awardee:	Maryland Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201
HCFA Project Officer:	Gina P. Clemons Center for Medicaid and State Operations

Description: The driving forces behind this statewide demonstration are the rapidly rising costs of Medicaid and the poor coordination of care in the current program for the sickest, most costly beneficiaries. The program has been developed on the basis of several guiding principles:

- Provide a patient-focused system.
- Build on the strengths of the current Maryland health care system.
- Provide comprehensive, prevention-oriented systems of care.
- Hold managed care organizations (MCOs) accountable for high-quality care.
- Achieve better value and predictability for State expenditures.

Maryland intends to enroll all waiver eligibles into an MCO or rare and expensive case management system. Mental health services will be provided under the demonstration in a separate fee-for-service delivery system.

Status: Initial enrollment in the demonstration began June 2, 1997, and continued through November 1997. Enrollment for new members will continue throughout the demonstration.

95-020 **State Health Care Reform Monitoring**

Project No.:	500-92-0035/0
Period:	September 1995-September 1998
Funding:	$1,464,511
Award:	Delivery Order
Principal Investigator:	Elicia Herz
Awardee:	MedStat Group, The 4401 Connecticut Avenue, NW. Washington, DC 20008
HCFA Project Officer:	Don Tabor Center for Medicaid and State Operations

Description: The purpose of this project is to assist States in implementing Section 1115 health care reform demonstrations and to assist HCFA in monitoring quality of care in these demonstrations. The MedStat Group will develop three guides: the first for use by States as they develop and implement encounter data systems, the second for the use of HCFA's Regional Offices (ROs) in monitoring the quality of care in Medicaid managed care, and the third for use by ROs in monitoring encounter data implementation by the States. Additionally, MedStat will provide direct technical assistance to States on encounter data and quality assurance issues. MedStat will also provide training sessions on related topics to the ROs in year two of the project.

Status: The contract was awarded on September 30, 1995. MedStat has developed two guides so far: the first for use by States as they develop and implement encounter data systems, and the second for the use of HCFA's ROs in monitoring and quality of care in the demonstrations. An additional guide will be completed for use by HCFA's ROs in monitoring encounter data implementation by the States. Thus far, MedStat has provided assistance to seven States (Delaware, Hawaii, Illinois, Minnesota, Oklahoma, Tennessee, and Vermont) on a wide variety of topics. RO training has also begun and will continue throughout fiscal year 1997.

94-126 **Evaluation of the State Medicaid Reform Demonstrations**

Project No.:	500-94-0047
Period:	September 1994-September 1999
Funding:	$5,636,584
Award:	Contract
Principal Investigator:	Judith Wooldridge
Awardee:	Mathematica Policy Research, Inc.

	600 Maryland Ave., SW., Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	James P. Hadley Office of Strategic Planning

Description: Mathematica is evaluating Hawaii, Rhode Island, Tennessee, Oklahoma, and Maryland's State Health Reform Demonstrations. The evaluator is conducting State-specific and cross-State analyses of demonstration impacts on utilization, insurance coverage, public and private expenditures, quality, access, and satisfaction. Analyses of all groups will, where possible, be stratified by age, income, geographic location, and other relevant demographic variables. Data will come from site visit interviews with providers, advocacy groups, and State officials; participant surveys; State Medicaid Management Information Systems and encounter data; hospital discharge data; routine cost reports from the State and providers; vital records; and secondary data sources such as the area resource file and current population survey. During 1996, two important design and funding additions were made to the project through interagency cooperative agreements. The Assistant Secretary for Planning and Evaluation contributed $1.2 million to enhance the evaluation's examination of the demonstrations' impacts on the disabled, and the Substance Abuse and the Mental Health Services Administration contributed an additional $400,000 to enhance the evaluation's assessment of the demonstrations' impacts on mental health and substance abuse service users.

Status: Reports available include the Final Evaluation Design and First Year Implementation Studies for the Tennessee, Rhode Island, Hawaii, and Oklahoma demonstrations. Consumer surveys to assess access, utilization, quality, and satisfaction will be fielded in the spring of 1998.

93-072 Study of State Health Care Reform Initiatives

Project No.:	500-92-0033/03
Period:	September 1993-March 1998
Funding:	$548,572
Award:	Delivery Order
Principal Investigator:	James S. Lubalin, Ph.D.
Awardee:	Research Triangle Institute 1615 M Street, NW., Suite 740 Washington, DC 20036-3209
HCFA Project Officer:	Gloria J. Smiddy Center for Medicaid and State Operations

Description: The purpose of this contract is to assist HCFA's Center for Medicaid and State Operations, and States, to develop and implement Medicaid program innovations and/or State health system reforms. The contract has three main objectives. The first is to document the progress of States that have begun reform efforts by creating a library of information that can be updated as the implementation of reform occurs. The second is to facilitate the streamlining of the section 1115 demonstration waiver process by providing recommendations to HCFA on how to revise and simplify the guidelines for project proposals, waiver cost estimates, and evaluation designs. The third is to provide technical assistance to States, helping them through the development of demonstration proposals, evaluation designs, and issue papers.

Status: In July 1997, the contract was extended until March 31, 1998. The project is in the final phase of operations.

95-028 Evaluation of the Diamond State Health Plan

Project No.:	500-92-0033/04
Period:	September 1994-September 1999
Funding:	$498,035
Award:	Delivery Order
Principal Investigator:	James S. Lubalin, Ph.D.
Awardee:	Research Triangle Institute 1615 M Street, NW., Suite 740 Washington, DC 20036-3209
HCFA Project Officer:	Penelope L. Pine Office of Strategic Planning

Description: This evaluation is being conducted by Research Triangle Institute (RTI) and its subcontractor, Health Economics Research, Inc. (HERI). The original purpose of the contract was to evaluate the Delaware Health Care Partnership for Children, specifically the effectiveness of the demonstration in reaching its goal of improving access to and the quality of health care services delivered to Medicaid-eligible children in a cost-effective way. The State believed that by enrolling children into a managed-care system operated by the Nemours Foundation, they would reap the benefits of a

higher level of coordinated care, while the State, and in turn the Federal Government, would benefit from lower Medicaid costs. In May 1996, RTI/HERI requested a modification to their contract to focus more generally on the impacts of the Diamond State Health Plan (DSHP) on children, including children with special health care needs (the original evaluation had been limited to the Nemours Children's Clinics). The goal of the evaluation was broadened to assess whether this section 1115 demonstration's objective of increased access to high-quality, cost-effective care for Medicaid children is being met. In May 1996, RTI/HERI also requested a 2-year no-cost extension (through September 29, 1999).

Status: The project is in the fourth year of the evaluation. One site visit was conducted in May 1996 and addressed issues pertaining to the early stages of implementation of the DSHP. The requested contract modification and no-cost extension were approved on March 14, 1997. The following changes to the scope of work were included:

- Conduct a second site visit to Delaware in 1998.
- Perform analyses of the impacts of the DSHP on children.
- Perform episode-of-care analyses of the impact of DSHP on children with special health care needs.
- Acquire, evaluate, and analyze DSHP encounter data for 1996 and 1997.

The schedule of deliverables has also been revised. The final report of the evaluation is due September 29, 1999.

97-024 **Evaluation of the Ohio Behavioral Health Program**

Project No.:	500-95-0048/05
Period:	September 1997-September 2001
Funding:	$579,216
Award:	Task Order
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Penelope L. Pine Office of Strategic Planning

Description: The project will address the following two components:

- A focused evaluation of the behavioral health component of OhioCare
- A case study of the implementation of Ohio's section 1115 State health reform demonstration, OhioCare.

The case study will complement the focused evaluation by providing context for and supplementing its findings. Both State 1915 waiver programs and 1115 demonstrations have been vehicles for creating managed care systems for the delivery of behavioral health--mental health and substance abuse--services. Managed care utilization management techniques are aimed at shifting beneficiaries from expensive inpatient care to less expensive settings, while maintaining, or even improving, appropriateness and quality of care. Integrated delivery systems can have the benefits of coordination of care, quality management, and accountability. Risk exists, however, of under treatment and cost shifting due to financial incentives. Since beneficiaries who use behavioral health care services are often unable to identify treatment needs, both coordination of services and safeguards against under treatment are vital components of behavioral health managed care programs.

Most States, including Ohio, are pursuing a carve-out approach. Although this approach has the benefits of helping to protect funding for behavioral health services, and creating a specialized health care system for beneficiaries who need these services, it also can result in a lack of coordination between behavioral and physical health care services.

The evaluation will focus on the effect of the Ohio program on beneficiaries with serious mental disorders and/or addiction disorders:

- Children and adolescents with continuing and severe mental health problems and/or serious emotional disorders.
- Children and adolescents with alcohol and/or other drug addiction.
- Adults with continuing and severe mental health problems.
- Adults with alcohol and/or other drug addiction.
- Persons with co-morbid condition of mental illness and alcohol and/or other drug addiction.
- Pregnant women who abuse or are addicted to alcohol and/or other drugs.

The evaluation is designed to assess the effect of Ohio's Specialty Managed Care for Behavioral Health Services Program on the delivery of behavioral health services. It will address the following questions:

- What is the program's effect on coordination and continuity of care, among behavioral health services, and between behavioral and physical health services?
- Is it clear which entity is accountable for treatment decisions and appeals?
- What is the program's effect on access to care?
- What is the program's effect on quality of care, including process of care, satisfaction with care, functional status, and health status?
- What is the program's effect on the use and cost of services?
- To what degree are the following outcomes occurring: shifting between systems, duplication of services, duplication of payments?

Status: Subsequent to the award of this evaluation, it was learned that there may be changes in the OhioCare program. As we await the details of these changes, the project's schedule is being delayed.

94-127 Evaluation of the Oregon Medicaid Demonstration

Project No.:	500-94-0056
Period:	September 1994-September 1999
Funding:	$4,433,954
Award:	Contract
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	Paul J. Boben, Ph.D. Office of Strategic Planning

Description: The objectives of the Oregon Medicaid Reform Demonstration are to increase the number of individuals with access to affordable health care services and to contain State and Federal expenditures for health care. Under the demonstration, Medicaid coverage is made available to all State residents with family incomes less than or equal to the Federal poverty level (FPL) and who meet an assets test. Two distinct strategies are used to generate the program savings needed to support the expanded enrollee population. The Medicaid benefit package is restructured by establishing a prioritized list of conditions and related treatments (CT pairs), limiting coverage to a pre-established number of CT pairs, and expanding the use of managed care for the delivery of Medicaid services. The demonstration began operation on February 1, 1994, and is scheduled to run for 5 years. The objectives of the evaluation are to determine the impact of the demonstration on access to care, quality of care, enrollee satisfaction, and the cost of care, for both new enrollees and those previously enrolled in Medicaid. To the extent possible, the impact of the prioritized list and the increased use of managed care will be identified separately. Other areas of interest include the impact of the demonstration on the number of uninsured in the State, provider participation and satisfaction, and the number of private employers who offer health insurance as a fringe benefit. The evaluation also will assess whether the concepts being tested in Oregon can be used in other States.

Status: As initially conceived, the scope of the evaluation was restricted to Phase I of the demonstration, in which only Aid to Families with Dependent Children (AFDC) and AFDC-related Medicaid recipients, as well as individuals with incomes under 100 percent of the FPL made eligible by the demonstration, would participate. Contract modifications made in September 1995 and September 1997 expanded the scope of the evaluation to include aged, blind, and disabled Medicaid beneficiaries who began participation under Phase II of the demonstration. The new analyses will be similar to those described above for the Phase I evaluation. In addition to Medicaid claims and encounter data, the evaluator will make use of disability data furnished by the Social Security Administration, as well as disability-related databases maintained by the State. The portion of the evaluation focusing on disabled recipients is sponsored jointly by HCFA's Office of Strategic Planning and the Office of the Assistant Secretary for Planning and Evaluation.

91-083 Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: South Carolina Health Access Plan

Project No.:	11-C-99653/4
Period:	September 1991-August 1997
Funding:	$500,000

Award:	Cooperative Agreement
Principal Investigator:	Bruce Bondo
Awardee:	South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206
HCFA Project Officer:	James P. Hadley Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1990

Description: Section 4745 of the Omnibus Budget Reconciliation Act of 1990 mandated a 3-year demonstration project to test the effect of eliminating the categorical eligibility requirement and raising the financial eligibility limits to 150 percent of the Federal poverty level (FPL) on low-income individuals' access to and cost of health care. In two South Carolina counties (Hoary and Marion), uninsured individuals below 150 percent of the FPL who were employed by small firms that had not offered health insurance coverage to their employees within the past 12 months were offered coverage for themselves and their families. To be eligible for participation, employers had to be located in 1 of the 2 demonstration counties, employ a minimum of 3 and a maximum of 100 employees, and not offered health insurance within the past 12 months. Individuals employed were eligible if they have South Carolina residency; have total family incomes under 150 percent of the FPL; are under 65 years of age; and were not currently covered by Medicaid, Medicare, or other health insurance programs. All care was delivered through a primary-care gatekeeper system. Physicians in the demonstration area who met the credential requirement for participation in Medicaid were recruited to participate in the demonstration. Each participating physician was paid a monthly fee of $2 per enrollee to manage the care of each assigned patient. Demonstration recipients were able to choose a physician gatekeeper from a list of participating physicians for their health care, as well as an early, periodic screening, diagnosis, and treatment (EPSDT) provider for their children's health care (both could be the same person if the selected physician gatekeeper is also an EPSDT screener). The primary-care physician gatekeeper was responsible for managing, coordinating, and controlling the member's/family's use of health care services through the direct provision of comprehensive primary care services (including providing for 24-hour, 7-day-a-week access by telephone), authorizing specialist visits, and granting prior approval of any hospitalizations.

Status: The project received an extension until September 30, 1997, and ended on that date. An evaluation of the demonstration, along with two other similar demonstrations, was conducted by Health Economics Research, Inc. The final report, "Evaluation of the Medicaid Expansion Demonstration," was completed and submitted in December 1997.

92-064 Evaluation of the Medicaid Uninsured Demonstrations

Project No.:	500-92-0062
Period:	September 1992-September 1997
Funding:	$1,313,458
Award:	Contract
Principal Investigator:	Margo L. Rosenbach, Ph.D.
Awardee:	Health Economics Research, Inc. 411 Waverly Oaks Road, Suite 330 Waltham, MA 02154
HCFA Project Officer:	James P. Hadley Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1990

Description: The purpose of this contract was to design and conduct the evaluation of three demonstration projects being conducted in Maine, South Carolina, and Washington State. These demonstrations, implemented in response to a congressional mandate under Section 4745 of the Omnibus Budget Reconciliation Act of 1990, were intended to test the effect of allowing States to extend Medicaid coverage to low-income families. Evaluation contract deliverables included an interim and a final evaluation report. The evaluator will examine within and between site processes and outcomes, including the following:

- Ability of the programs to enroll significant numbers of eligible persons.
- Conditions under which eligible persons and their families are willing to participate in such programs, given their scarce financial resources.
- Ability of the programs to induce adequate numbers of providers to ensure the availability of necessary

services at appropriate levels of utilization.

- Willingness of employers to participate in the programs and the conditions under which they do or do not choose to do so.
- Program's effect on service utilization and health outcomes of participants.
- Cost effectiveness of such programs for the various public and private interests.
- Extent to which the demonstration's interventions could be applied nationally to assist in achieving program goals.

Status: The evaluation is complete. The final report, "Evaluation of the Medicaid Expansion Demonstration," was submitted December 5, 1997.

97-019 Report of Anthony Lehman/Tennessee Evaluation

Project No.:	HCFA-97-0180
Period:	May 1997-March 1998
Funding:	$25,000
Award:	Purchase Order
Principal Investigator:	Anthony Lehman, M.D.
Awardee:	Anthony Lehman, M.D. 1013 Litchfield Road Baltimore, MD 21239
HCFA Project Officer:	Rose M. Hatten Center for Medicaid and State Operations

Description: This study will provide an assessment of implementation and the impact of a corrective action plan by the State of Tennessee for TennCare Partners' mental health portion of Section 1115 Waiver Only Project No. 11-W-00002/4, entitled "TennCare".

Status: Planning meetings between project officer and principal investigator have begun.

97-015 Fiscal Issues for the District of Columbia Behavioral Health Managed Care Initiative Demonstration Development

Project No.:	500-95-0049/02
Period:	April 1997-April 1998
Funding:	$85,846
Award:	Task Order
Principal Investigator:	Gail Robinson
Awardee:	Lewin-VHI, Inc 9302 Lee Highway, Suite 500 Fairfax, VA 22031-1214
HCFA Project Officer:	Peggy Clark Center for Medicaid and State Operations

Description: The project will assist the District of Columbia's managed care initiative for behavioral health by developing an option paper outlining financial mechanism strategies (inclusive of benefits, modification, utilization management, negotiated discounts, limiting provider payments, etc.). Regarding payment rate recommendations, the contractor has done an analysis of what some other jurisdictions have done and written some recommendations to help formulate the best process for rate structure and rates. The project has identified, assessed and recommended which financing structures can best support payment of continuing care services for individuals disabled by behavioral health illnesses, ready for discharge from acute care and require continuing care when such services are at capacity. The project was expanded to include the construction of rates and service definitions through interviewing mental health and substance abuse representatives responsible for overseeing these services and programs in three cities with characteristics similar to the District. Finally, the contractor will develop a rate review process by: summarizing bidding options in a slide presentation; presenting each step-down or diversionary service along with a proposed range of rates for each service in a table; and summarizing a rate review process for evaluating provider bids in a slide presentation.

Status: The project is underway, but the contractor may encounter some delays in interviewing staff responsible for budgeting and financing services, due to 1997 end-of-year holiday vacation schedules. The contractor will review its progress in mid-January and let HCFA know if additional time is needed to complete the deliverables.

96-040 Oakland's Enhanced Enterprise Community--Community Building Team Program

Project No.:	11-W-00072/9-0
Period:	February 1996-February 2006
Award:	Waiver-only Project
Principal Investigator:	Eloise Anderson/Bruce Wagstaff

Awardee:	Department of Social Services 744 P Street Sacramento, CA 95814
HCFA Project Officer:	Alisa Adamo Center for Medicaid and State Operations

Description: The demonstration project is part of the larger empowerment zone/enterprise community effort authorized by Congress. The purpose of the empowerment zone legislation is to provide Federal support for innovative, locally-designed efforts to improve the quality of life in low income urban communities. It provides an opportunity for cities that have been designated empowerment zones or enterprise communities to develop innovative programs to bring economic self-sufficiency and revitalization to their most distressed areas. Six urban empowerment zones and 65 enterprise communities were designated on the basis of community-based strategic plans which presented comprehensive economic self-sufficiency community revitalization. The focus of the programs is on comprehensive neighborhood revitalization, rather than on welfare reform. One of the benefits of the designation is the prompt waiver of regulations preventing creative and effective revitalization programs. This was the first empowerment zone/enterprise community waiver request.

In December 1994, Oakland was designated as an enhanced enterprise community (EEC) and granted $3 million in Social Services Block Grant funds. The EEC is part of an ambitious large-scale, multi-dimensional strategic plan for Oakland. Oakland's project is based on the assumption that single-purpose interventions--whether they be in housing, job training, social services, or health care--will not suffice to revitalize distressed neighborhoods and create economic self sufficiency among the residents of those neighborhoods. Instead, the enterprise community demonstration program in concentrated areas includes multi-dimensional interventions and participation from all facets of community institutions. The enterprise community strategy places community residents in the position of the key implementers of the program, and thereby moves them from the experience of dependency to the experience of empowerment to change their communities and their own lives.

The Community Building Team (CBT) program is the central empowerment strategy of Oakland's enterprise community. The hypothesis of the CBT program is that individuals who are placed in a position of leadership and given an opportunity to be a resource to their community will be motivated to develop their own potential and will be good role models in their community. The CBT program blends job and skills training for EEC area residents with an opportunity for them to directly assist in their neighborhoods' revitalization.

Six CBTs have been established in six target area and are comprised of six area residents. Approximately half of the team members are Aid to Families with Dependent Children (AFDC) recipients. The teams will operate for 2 years as they identify problems and work with the neighborhood to develop solutions. During months 1-12, the participants receive a cash work and training stipend. Participants are also being provided with transportation, child care, and health insurance, as necessary. Additionally, during this time the participants will undergo education and job skills assessment to identify remedial educational needs and job interests. At the end of year one, participants will be placed in education or internship environments, and a $5,000 stipend will be provided to the training or educational institution.

The CBT program is the core of Oakland's EEC's empowerment efforts, and the project required various waivers from Administration for Children and Families (ACF) and HCFA. The waivers from HCFA disregard the project's payments to AFDC and Medi-Cal recipients when establishing eligibility or computing grant levels.

Status: With the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 on August 22, 1996, States were permitted to continue many of the policies that had previously required waivers of pre-welfare reform title IV-A by submitting a Temporary Assistance for Needy Families plan to the ACF. In some instances, States elected to retain waivers of pre-welfare reform title IV-A through the end of the demonstration period. HCFA does not have any information on the continuation of these waivers. Unless otherwise indicated, States have elected to retain the waivers and expenditures authorities granted by HCFA as part of the welfare reform demonstrations.

WELFARE REFORM DEMONSTRATION PROJECTS

Description: In advance of the major nationwide revision in welfare a number of States experimented with changes in their programs. HCFA assisted these welfare demonstrations by approving waivers of the specific Medicaid regulations needed to permit each project to operate.

Arizona

95-047 **Arizona Welfare Reform: Employing and Moving People off Welfare and Encouraging Responsibility Program**
Project No.: 11-W-00058/9

California

93-005 **California Welfare Reform: Assistance Payments Demonstration Project**
Project No.: 11-W-00018/9A

96-065 **California Welfare Reform: California Work Pays Demonstration Project**
Project No.: 11-W-00018/9B

Colorado

94-071 **Colorado Welfare Reform: Personal Responsibility and Employment Program**
Project No.: 11-W-00009/8

Connecticut

94-069 **Connecticut Welfare Reform: Reach for Jobs First**
Project No.: 11-W-00022/1

Delaware

95-068 **A Better Chance Welfare Reform Project**
Project No.: 11-W-00056/3

Florida

94-068 **Florida Welfare Reform: Family Transition Program**
Project No.: 11-W-00011/4

Illinois

93-042 **Illinois Welfare Reform: Project Fresh Start--Homeless Families Stabilization Component**
Project No.: 11-P-90242/5

Maine

96-064 **Maine Welfare Reform: Welfare to Work**
Project No.: 11-W-00084/1

Maryland

95-048 **Maryland Welfare Reform: Family Investment Program**
Project No.: 11-W-00066/3

Massachusetts

95-069 **Massachusetts Welfare Reform, 1995**
Project No.: 11-W-00065/1

Michigan

96-041 **To Strengthen Michigan Families**
Project No.: 11-W-00093-5

Minnesota

96-042 **Minnesota's Work First Demonstration**
Project No.: 11-W-00103/5

Mississippi

96-046 **Mississippi New Direction Welfare Reform Demonstration Project--Amendment**
Project No.: 11-W-00071/4-01

Montana

95-049 **Montana Welfare Reform: Families Achieving Independence in Montana**
Project No.: 11-W-00040/8

Nebraska

95-062 **Nebraska Welfare Reform Demonstration Project**
Project No.: 11-W-00055/7

New Hampshire

96-047 New Hampshire Employment Program and Family Assistance Program
Project No.: 11-W-00083/1

New Jersey
92-041 New Jersey Welfare Reform: Family Development Program
Project No.: 11-W-00016/2

Pennsylvania

95-065 Pennsylvania Welfare Reform: Pennsylvania Pathways to Independence
Project No.: 11-W-00044/3

South Carolina

96-063 South Carolina Welfare Reform: Family Independence Act
Project No.: 11-W-00081/4

Tennessee

96-043 Tennessee "Families First" Demonstration
Project No.: 11-W-00104/4

Texas

96-044 Achieving Change For Texans
Project No.: 11-W-00080/6

Utah

92-066 Utah Welfare Reform: Single Parent Employment Demonstration
Project No.: 11-W-00019/8

Vermont
93-063 Vermont Welfare Reform: Family Independence Project
Project No.: 11-P-90238/1

Virginia

95-063 Virginia Independence Program
Project No.: 11-W-00062/3

Wisconsin

88-002 Wisconsin State Welfare Reform Demonstration
Project No.: 11-W-00041/5

92-042 Wisconsin Welfare Reform: Two-Tier Aid to Families with Dependent Children Benefit Demonstration
Project No.: 11-P-90167/5

94-067 Wisconsin Welfare Reform: Work Not Welfare
Project No.: 11-W-00006/5

96-048 New Hope Project
Project No.: 11-W-00098-5

84-006 Social Health Maintenance Organization Project for Long-Term Care: Kaiser Permanente Center for Health Research (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09103/0
Period:	August 1984-December 2000
Award:	Waiver-only Project
Principal Investigator:	Lucy Nonnenkamp
Awardee:	Kaiser Permanente Center for Health Research 3800 North Kaiser Center Drive Portland, OR 97227-1098
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers
Mandates:	Deficit Reduction Act of 1984; Omnibus Budget Reconciliation Act of 1987; Omnibus Budget Reconciliation Act of 1990; Omnibus Budget Reconciliation Act of 1993; Balanced Budget Act of 1997

Description: In accordance with section 2355 of the Deficit Reduction Act of 1984, this project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the

S/HMO at a fixed, annual, prepaid capitation sum. Four sites were selected to participate; of the four, two were health maintenance organizations (HMO) that have added long-term-care services to their existing service packages and two were long-term-care providers that have added acute-care service packages. Kaiser Permanente Center for Health Research (doing business as Medicare Plus II) is one of the HMO sites that developed and added a long-term-care component to its service package. HealthPartners (formerly Group Health in Minneapolis-St. Paul, Minnesota), one of the original sites, discontinued participation on January 1, 1995.

Status: Medicare Plus II implemented its service delivery network in March 1985. Medicare Plus II uses Medicare waivers only. During the first 30 months of operation, Federal and State Governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On four separate occasions, this demonstration has been extended by legislation. The Balanced Budget Act of 1997, extends the demonstration period through December 31, 2000. However, the Secretary must submit a report to Congress by January 1, 1999, that addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations.

84-004 Social Health Maintenance Organization Project for Long-Term Care: Elderplan, Inc. (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09101/2
Period:	August 1984-December 2000
Award:	Waiver-only Project
Principal Investigator:	Eli Feldman
Awardee:	Elderplan, Inc. 6323 Seventh Avenue Brooklyn, NY 11220
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers
Mandates:	Deficit Reduction Act of 1984; Omnibus Budget Reconciliation Act of 1987; Omnibus Budget Reconciliation Act of 1990; Omnibus Budget Reconciliation Act of 1993; Balanced Budget Act of 1997

Description: In accordance with section 2355 of the Deficit Reduction Act of 1984, this project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites were selected to participate; of the four, two were health maintenance organizations that have added long-term-care services to their existing service packages and two were long-term-care providers that have added acute-care service packages. Elderplan is one of the long-term-care provider sites that developed and added an acute-care service component. HealthPartners (formerly Group Health in Minneapolis-St. Paul, Minnesota), one of the original sites, discontinued participation on January 1, 1995.

Status: Elderplan implemented its service delivery network in March 1985. Elderplan uses both Medicare and Medicaid waivers. During the first 30 months of operation, Federal and State Governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On four separate occasions, this demonstration has been extended by legislation. Current legislation,the Balanced Budget Act of 1997, extends the demonstration period through December 31, 2000. However, the Secretary must submit a report to Congress by January 1, 1999, that addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations.

84-007 Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09104/9
Period:	August 1984-December 2000
Award:	Waiver-only Project
Principal Investigator:	Sam Ervin
Awardee:	SCAN Health Plan 3780 Kilroy Airport Way, Suite 600 P.O. Box 22616 Long Beach, CA 90801-5616
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

Mandates: Deficit Reduction Act of 1984; Omnibus Budget Reconciliation Act of 1987; Omnibus Budget Reconciliation Act of 1990; Omnibus Budget Reconciliation Act of 1993; Balanced Budget Act of 1997

Description: In accordance with section 2355 of the Deficit Reduction Act of 1984, this project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four sites were selected to participate; of the four, two were health maintenance organizations that have added long-term-care services to their existing service packages and two were long-term care providers that have added acute-care service packages. SCAN Health Plan is one of the long-term-care provider sites that developed and added an acute care service component. HealthPartners (formerly Group Health in Minneapolis-St. Paul, Minnesota), one of the original sites, discontinued participation on January 1, 1995.

Status: SCAN Health Plan implemented its service delivery network in March 1985. SCAN uses both Medicare and Medicaid waivers. During the first 30 months of operation, Federal and State Governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On four separate occasions, this demonstration has been extended by legislation. Current legislation, the Balanced Budget Act of 1997, extends the demonstration period through December 31, 2000. However, the Secretary must submit a report to Congress by January 1, 1999, that addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations.

SECOND GENERATION SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION

Mandates: Omnibus Budget Reconciliation Act of 1990

Description: In accordance with section 2355 of the Deficit Reduction Act of 1984, the concept of a social health maintenance organization (S/HMO) was developed and implemented. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term-care services are provided by or through the S/HMO at a fixed annual prepaid capitation sum. Section 4207(b)(4) of the Omnibus Budget Reconciliation Act of 1990 authorized the expansion of the Social Health Maintenance Organization demonstration. The purpose of this second-generation S/HMO (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO-II model will also provide an opportunity to test more geriatrically oriented models of care. Six organizations were selected to participate in the project; the status of these individual projects is described below.

95-087 Second Generation Social Health Maintenance Organization Demonstration: South Carolina

Project No.:	95-W-90500/4-0
Period:	November 1996-December 2000
Award:	Waiver-only Project
Principal Investigator:	Thomas Brown, Ph.D.
Awardee:	Richland Memorial Hospital Five Richland Medical Park Columbia, SC 29203-6897
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

Status: The site has indicated that it is not going forward with implementation of the project.

95-088 Second Generation Social Health Maintenance Organization Demonstration: Nevada

Project No.:	95-W-90503/9-0
Period:	November 1996-December 2000
Award:	Waiver-only Project
Principal Investigator:	Bonnie Hillegass
Awardee:	Health Plan of Nevada, Inc. P.O. Box 15645 Las Vegas, NV 89114-5645
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

Status: The Health Plan of Nevada began enrolling Medicare beneficiaries into the S/HMO-II demonstration in November 1996. They continue to participate as an operational site as of December 1997.

95-090 Second Generation Social Health Maintenance Organization Demonstration: Colorado

Project No.:	95-W-90498/8-0
Period:	November 1996-December 2000
Award:	Waiver-only Project
Principal Investigator:	Margaret Hearndon
Awardee:	Rocky Mountain Health Maintenance Organization 2775 Crossroads Boulevard Grand Junction, CO 81506
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

Status: As of the end of December 1997, the site had not yet begun implementation.

95-091 Second Generation Social Health Maintenance Organization Demonstration: Florida

Project No.:	95-W-90501/4-0
Period:	November 1996-December 2000
Award:	Waiver-only Project
Principal Investigator:	JoAnne Dutcher
Awardee:	CAC Ramsey Health Plan 75 Valencia Avenue Coral Gables, FL 33134
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

Status: The site has indicated that it is not going forward with implementation of the project.

95-086 Second Generation Social Health Maintenance Organization Demonstration: Massachusetts

Project No.:	95-W-90496/1-0
Period:	November 1996-December 2000
Award:	Waiver-only Project
Principal Investigator:	Linda Fitzpatrick
Awardee:	Fallon Community Health Plan Chestnut Place 10 Chestnut Street Worcester, MA 01608-2810
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

Status: The site has indicated that it is not going forward with implementation of the project.

95-085 Second Generation Social Health Maintenance Organization Demonstration: California

Project No.:	95-W-90493/9-0
Period:	November 1996-December 2000
Award:	Waiver-Only Project
Principal Investigator:	Bobbi Baron
Awardee:	Contra Costa County Health Plan 595 Center Avenue, Suite 100 Martinez, CA 94553-4639
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

Status: At the current time, preimplementation activities are underway. Social Health Maintenance Organization
Capitation
managed care

93-078 Site Development and Technical Assistance for the Second Generation Social Health Maintenance Organization Demonstration

Project No.:	500-93-0033
Period:	September 1993-September 1998
Funding:	$2,251,123
Award:	Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	University of Minnesota School of Public Health Institute for Health Services Research D-351 Mayo Memorial Building 420 Delaware Street, SE. Minneapolis, MN 55455-0392
HCFA Project Officer:	Thomas Theis Center for Health Plans and

Providers

Mandates: Omnibus Budget Reconciliation Act of 1990

Description: In January 1995, HCFA selected six organizations to participate in the Second Generation Social Health Maintenance Organization (HMO) Demonstration. The purpose of this project is to study the impact of integrating acute-and-long term-care-services within a capitated managed-care system. It was developed to refine the targeting and financing methodologies and the benefit design of the current social HMO model, which was initiated as a demonstration in 1985.

Although the same services are provided under both of these projects, the Second Generation Social HMO Demonstration features a greater emphasis on geriatric care and a more inclusive case management system. Another distinguishing characteristic of the project is its risk-adjusted payment methodology that is based on an individual's health status and functioning level. The primary focus of the project's evaluation will be to compare beneficiaries enrolled in the demonstration with beneficiaries in a section 1876 HMO program.

The University of Minnesota and its subcontractor, the University of California at San Francisco are providing technical assistance and support in the development, implementation, and operation of the Second Generation Social HMO Demonstration.

Status: The developmental phase of the Second Generation Social HMO Demonstration began in January 1995. Since that time the University of Minnesota and the University of California at San Francisco have been providing technical assistance to the organizations participating in the project. They have also developed a questionnaire that is being used to determine a beneficiary's capitated payment rate, a series of geriatric protocols is being used to help physicians identify and treat certain health conditions, and a care coordination assessment instrument is being used to assist case managers with care planning. The Health Plan of Nevada began enrolling beneficiaries in the demonstration in November 1996.

97-210 **Data Collection for Second Generation SHMO**

Project No.: 500-96-0005/02
Period: November 1996-November 1999
Funding: $4,568,370
Award: Task Order
Principal Investigator: Lisa Alexich
Awardee: Lewin-VHI, Inc.
9300 Lee Highway, Suite 500
Fairfax, VA 22031-1207
HCFA Project Officer: Thomas Theis
Center for Health Plans and Providers

Mandates: Deficit Reduction Act of 1984; Omnibus Budget Reconciliation Act of 1987; Omnibus Budget Reconciliation Act of 1990; Omnibus Budget Reconciliation Act of 1993

Description: This project consolidates the data collection needs of the Second Generation Social Health Maintenance Organization (S/HMO-II) Demonstration. Work is being performed by Mathematica Policy Research, Inc., under a subcontract. The project is conducting initial and annual follow-up surveys for each beneficiary enrolled in the S/HMO-II demonstration. The information gathered serves three primary functions:

- Baseline and follow-up data for the evaluation.
- Clinical information to the participating S/HMO-II sites for care planning.
- Data for risk-adjustment.

Status: Data collection is underway.

93-006 **Managing Medical Care for Nursing Home Residents: United HealthCare Corporation, Inc.**

Project No.: 95-C-90174
Period: December 1992-December 1998
Award: Waiver-only Project
Principal Investigator: Marcia Smith
Awardee: United HealthCare Corporation, Inc.
P.O. Box 1459
Minneapolis, MN 55440-8001
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

Description: The objective of this demonstration is to study the effectiveness of managing acute care needs of nursing home residents by pairing physicians and geriatric nurse practitioners (GNP), who will function as primary medical caregivers and case managers. The major goals are to reduce medical complications and dislocation trauma resulting from hospitalization and to save the expense of hospital care when patients could be managed safely in nursing homes with expanded services. The operating principal is EverCare, a subsidiary of United HealthCare Corporation, Inc. EverCare will receive a fixed capitated payment (based on a percentage of the adjusted average per capita cost) for all nursing home residents enrolled and will be at full financial risk for the cost of acute care services for the enrollees. Nine demonstration sites are expected to participate, with each site enrolling approximately 300 persons. GNPs will provide initial assessments of enrollees; make monthly visits; authorize clinic, outpatient, and hospital visits; and communicate with the patients' physicians, nursing facility staffs, and families. Physician incentive plans will be structured to offer a higher reimbursement rate for a nursing home visit and a lower reimbursement rate for services furnished in physicians' offices or in other settings. By increasing the intensity and availability of medical services, EverCare believes that this case management model will reduce total care costs, improve the quality of care received by participants through better coordination of appropriate acute care services, and improve the quality of life for and the level of satisfaction of enrollees and their families.

Status: Six sites are currently operational: Boston, Baltimore, Atlanta, Denver, Phoenix and Tampa. No additional sites are planned. Total site enrollment is 5,519. Sites are experiencing differences which, in certain clinical care issues, have initiated actions to determine contributing factors. The results will be used to develop support clinical protocols.

97-216 **Evaluation of the Evercare Demonstration Program**

Project No.:	500-96-0008/02
Period:	September 1997-March 2001
Funding:	$1,488,082
Award:	Task Order
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	University of Minnesota 420 Delaware Street, SE. Minneapolis, MN 55455-0392
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning

Description: In late summer 1994, Medicare waivers were granted to EverCare, a subsidiary of the United Health Care Corporation, Inc., for the purpose of conducting a demonstration to test the effectiveness of managing the acute care needs of permanent nursing home residents. This care management is effected by pairing geriatric nurse practitioners (GNPs) with physicians who have an interest and/or experience in treating geriatric patients. Under the demonstration design, GNPs function as primary medical care givers and case managers. The major goals of the demonstration are to reduce medical complications and dislocation trauma resulting from hospitalization, and to save the expense of hospital care when patients could be managed safely in nursing homes with expanded services. The EverCare evaluation will combine data from site case studies, a network analysis of nurse practitioners, participant and caregiver surveys, and participant utilization data to examine the following areas:

- A comparison of enrollees and non-enrollees
- Process of implementation and operation of EverCare
- Changes in the care process, as well as quality of care
- Effect of the demonstration on various types of providers
- Effect of the demonstration on enrollees' health and health care utilization
- Satisfaction on enrollees and their families
- Effect of the demonstration on the costs of care, as well as payment sources.

For each EverCare site, of which there are six, two comparison groups will be selected -- non-participating residents in EverCare site nursing homes and residents in non-participating nursing homes operating in EverCare demonstration cities.

Status: An initial meeting was held with the principal investigator in October. A site visit has been conducted with the original EverCare site in Minneapolis and site visits are being scheduled for early 1998 to the EverCare

demonstration sites. A draft survey instrument is being constructed.

97-018 **Age Well Option (now referred to as TLC)**

Project No.:	18-P-90748/1-01
Period:	May 1997-April 2002
Funding:	$750,000
Award:	Grant
Principal Investigator:	Lewis A. Lipsitz, M.D.
Awardee:	Hebrew Rehabilitation Center for the Aged 1200 Centre Street Boston, MA 02131-1097
HCFA Project Officer:	Stefan N. Miller Center for Health Plans and Providers

Description: Community care and educational protocols will be used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decision-making and chronic disease management. The populations that will be studied are individuals living in the Hebrew Rehabilitation Center for the Aged and those living in subsidized housing in the Boston area.

Status: This project is still in its developmental stage.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) DEMONSTRATION

Mandates:	Omnibus Budget Reconciliation Act of 1986; Omnibus Budget Reconciliation Act of 1987; Omnibus Budget Reconciliation Act of 1990

Description: The Health Care Financing Administartion is mandated by Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g)(1)(2) of the Omnibus Budget Reconciliation Act of 1987 and section 4744 of Omnibus Budget Reconciliation Act of 1990, to conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed-care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes, as core services, the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term-care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center, whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years. The sites listed below, and their State Medicaid agencies, have been granted waiver approval to provide services under this demonstration. .

Status: In response to changes in Title XVIII of the Social Security Act made by the Balanced Budget Act of 1997 establishes the Program of All-inclusive Care for the Elderly as a permanent part of the Medicare program and as a State Option under Medicaid. It is expected that the demonstration sites will transition from a demonstration to a permanent entity once regulations which implement this public law become effective.

84-001 **On Lok's Risk-Based Community Care Organization for Dependent Adults: On Lok Senior Health Services**

Project No.:	95-W-00013/98
Period:	November 1983-June 1997
Award:	Waiver-only Project
Principal Investigator:	Kate O'Malley
Awardee:	On Lok Senior Health Services 1333 Bush Street San Francisco, CA 94109
HCFA Project Officer:	Stefan N. Miller Center for Health Plans and Providers

84-008 **On Lok's Risk-Based Community Care Organization for Dependent Adults**

Project No.:	11-W-00105/9
Period:	November 1983-November 2000
Award:	Waiver-only Project

Principal Investigator: Louise Nava
Awardee: California Department of Health Services
714 P Street, Room 1400
San Francisco, CA 94234-7320
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

94-040 **Program of All-inclusive Care for the Elderly: Sutter Health System**

Project No.: 95-W-00005/9
Period: May 1994-April 1998
Award: Waiver-only Project
Principal Investigator: Janet Tedesco
Awardee: Sutter Health System
7000 Franklin Blvd., Suite 1020
Sacramento, CA 95823-1820
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

94-061 **Program of All-inclusive Care for the Elderly: California Department of Health Services**

Project No.: 11-W-00106/9
Period: May 1994-May 1998
Award: Waiver-only Project
Principal Investigator: Louise Nava
Awardee: California Department of Health Services
714 P Street, Room 1400
Sacramento, CA 94234-7320
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

95-093 **Program of All-Inclusive Care for the Elderly: Center for Elders' Independence**

Project No.: 95-W-00003/9
Period: May 1995-May 1997
Award: Waiver-only Project
Principal Investigator: Peter Szutu
Awardee: Centers for Elders' Independence
1955 San Pablo Avenue
Oakland, CA 94612
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

95-092 **Program of All-inclusive Care for the Elderly: California Department of Health Services**

Project No.: 11-W-00087/9
Period: May 1995-May 1998
Award: Waiver-only Project
Principal Investigator: Della Cabera
Awardee: Department of Health Services
714 P Street, Room 1400
Sacramento, CA 95814
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-218 **Program of All-inclusive Care for the Elderly: Total Longterm Care**

Project No.: 95-W-00052/8
Period: October 1991-September 1997
Award: Waiver-only Project
Principal Investigator: David Reyes
Awardee: Total Longterm Care
3202 West Colfax Avenue
Denver, CO 80204
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-217 **Program of All-inclusive Care for the Elderly: Colorado Department of Health Policy & Financing**

Project No.: 11-W-00079/8
Period: October 1991-September 1999
Award: Waiver-only Project
Principal Investigator: Carole Workman-Allen
Awardee: Department of Health Policy and Financing
1575 Sherman Street
Denver, CO 80203
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-212 **Program of All-inclusive Care for the Elderly: East Boston Geriatric**

Project No.: 95-W-00006/1
Period: June 1989-May 1997

Award: Waiver-only Project
Principal Investigator: John Cradock
Awardee: East Boston Geriatric
10 Gove Street
East Boston, MA 02128
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-211 Program of All-inclusive Care for the Elderly: Massachusetts Division of Medical Assistance

Project No.: 11-W-00086/1
Period: June 1986-May 1997
Award: Waiver-only Project
Principal Investigator: Diane Flanders
Awardee: Division of Medical Assistance
600 Washington Street
Boston, MA 20111
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-208 Program of All-inclusive Care for the Elderly: Henry Ford

Project No.: 95-W-00053/5
Period: May 1997-May 1998
Award: Waiver-only Project
Principal Investigator: Michele Leport
Awardee: Henry Ford
One Ford Place, SE.
Detroit, MI 48202-3450
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-207 Program of All-inclusive Care for the Elderly: Michigan Department of Social Services

Project No.: 11-W-00112/5
Period: May 1997-May 1998
Award: Waiver-only Project
Principal Investigator: Vernon Smith
Awardee: Department of Social Services
235 S. Cesar Chavez Avenue
Lansing, MI 48909
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-206 Program of All-inclusive Care for the Elderly: Rochester Memorial

Project No.: 95-W-00004/2
Period: May 1990-May 1997
Award: Waiver-only Project
Principal Investigator: Kathryn McGuire
Awardee: Rochester Memorial
2066 Hudson Ave
Rochester, NY 14617
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-205 Program of All-inclusive Care for the Elderly: New York Department of Social Services

Project No.: 11-W-00088/2
Period: May 1990-May 1997
Award: Waiver-only Project
Principal Investigator: Mary Ann Monaco
Awardee: Department of Social Services
Room 1466
Corning Tower, Empire State Plaza
Albany, NY 12237
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-216 Program of All-inclusive Care for the Elderly: Beth Abraham

Project No.: 95-W-00025/2
Period: September 1989-August 1997
Award: Waiver-only Project
Principal Investigator: Geraldine Taylor
Awardee: Beth Abraham
612 Allerton Avenue
Bronx, NY 10467
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-215 Program of All-inclusive Care for the Elderly: New York Department of Social Services

Project No.: 11-W-00077/2
Period: September 1989-August 1997
Award: Waiver-only Project
Principal

Investigator: Mary Ann Monaco
Awardee: Department of Social Services
Room 1466
Corning Tower, Empire State Plaza
Albany, NY 12237
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-213 Program of All-inclusive Care for the Elderly: Providence Elderplace

Project No.: 95-P-99359
Period: June 1989-May 1997
Award: Waiver-only Project
Principal Investigator: Don Keister
Awardee: Providence ElderPlace
4540 N.E. Glisan Street
Portland, Oregon 97213
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-213 Program of All-inclusive Care for the Elderly: Oregon Department of Human Resources

Project No.: 11-W-00095/0
Period: June 1989-May 1997
Award: Waiver-only Project
Principal Investigator: Susan Dietsche
Awardee: Department of Human Resources
500 Summer St., NE., 2nd Floor
Salem, OR 97310-1015
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-220 Program of All-inclusive Care for the Elderly: Richland Memorial

Project No.: 95-W-00048/4
Period: October 1989-September 1997
Award: Waiver-only Project
Principal Investigator: Judith Baskins
Awardee: Richland Memorial
Five Richland Medical Park
Columbia, SC 29203
HCFA Officer: Stefan N. Miller
Center for Health Plans and Providers

98-219 Program of All-inclusive Care for the Elderly: South Carolina Department of Health and Human Services

Project No.: 11-W-00108/4
Period: October 1989-September 1997
Award: Waiver-only Project
Principal Investigator: Nicki Harvey
Awardee: South Carolina Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-210 Program of All-inclusive Care for the Elderly: Bienvivir Senior Health

Project No.: 95-W-00007/6
Period: June 1991-May 1997
Award: Waiver-only Project
Principal Investigator: John Cook
Awardee: Bienvivir Senior Health
940 N. Carolina Drive
El Paso, TX 79915
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-209 Program of All-inclusive Care for the Elderly: Texas Health and Human Services Commission

Project No.: 11-W-00101/6
Period: June 1991-May 1997
Award: Waiver-only Project
Principal Investigator: Anita Anderson
Awardee: Health and Human Services Commission
PO Box 13247
Austin, TX 78711
HCFA Project Officer: Stefan N. Miller
Center for Health Plans and Providers

98-222 Program of All-inclusive Care for the Elderly: Community Care

Project No.: 95-W-00002/5
Period: November 1989-October 1999

Award:	Waiver-only Project
Principal Investigator:	Kirby Shoaf
Awardee:	Community Care 1825 N. Prospect Avenue Milwaukee, WI 53202
HCFA Project Officer:	Stefan N. Miller Center for Health Plans and Providers

98-221 Program of All-inclusive Care for the Elderly: Wisconsin Department of Health and Social Services

Project No.:	11-W-00078/5
Period:	November 1989-October 1999
Award:	Waiver-only Project
Principal Investigator:	Richard Lorang
Awardee:	Department of Health and Social Services 1 West Wilson Street Madison, WI 53707-7850
HCFA Project Officer:	Stefan N. Miller Center for Health Plans and Providers

96-056 Program of All-inclusive Care for the Elderly Quality Assurance

Project No.:	500-96-0004/02
Period:	September 1990-March 1999
Funding:	$1,837,148
Award:	Task Order
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 S. Colorado Blvd., Suite 306 Denver, CO 80222
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning
Mandates:	Balanced Budget Act of 1997

Description: This project will develop an outcome-based quality assurance and performance improvement system for the Program of All-inclusive Care for the Elderly (PACE) for use by HCFA and States in monitoring sites and for continuous quality improvement (CQI). The CQI system will consist of two phases. In the first phase risk-adjusted outcome reports will be produced, while during the second phase the PACE sites will examine why and how they are achieving specific outcomes and make recommendations for improvements in the case of poor outcomes.

Status: Currently, the contractor is in the process of identifying outcome indicators and measures that would be relevant for the PACE population. At this point, outcome indicators are being developed in a number of different areas, including functional independence, medical problems, cognitive impairment, mental health, participant quality of life, caregiver quality of life, sentinel events, end of life, medication use, and health care utilization. Additionally, focus groups have been conducted with PACE participants and their caregivers to determine what is most important to them in the PACE program.

95-059 Program of All-inclusive Care for the Elderly Data Management

Project No.:	500-95-0035
Period:	September 1995-September 1998
Funding:	$590,630
Award:	Contract
Principal Investigator:	Marleen L. Clark, Ph.D.
Awardee:	On Lok, Inc. 1333 Bush Street San Francisco, CA 94109
HCFA Project Officer:	Kay Lewandowski Office of Strategic Planning

Description: The purpose of this contract is to provide data management for the Program of All-inclusive Care for the Elderly (PACE) demonstration period to ensure that a valid, reliable data set is maintained for monitoring project operations and for use by HCFA's independent evaluator. This is a continuation of the previous contract with On Lok, Inc. to provide this service. DataPACE maintains a data set on PACE enrollees and manages data collection procedures at the PACE sites. In the course of this second contract, service utilization data are scheduled to be used by the PACE demonstration program's independent evaluator.

Status: The DataPACE software and data management routines have been implemented at all sites and continue to be used to monitor data quality and provide feedback to the sites. The first round of data transmissions to the independent evaluator have taken place.

97-023 **PACE Rate Work**

Project No.:	500-96-0010/02
Period:	September 1997-September 1998
Funding:	$178,125
Award:	Task Order
Principal Investigator:	Catherine Hawes
Awardee:	Research Triangle Institute PO Box 12194 Research Triangle Park, NC 27709
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning
Mandates:	Balanced Budget Act of 1997 (Section 1894(d)(2))

Description: The purpose of this task order is to determine how Medicare costs for the nursing home certifiable population compare to Medicare costs for the overall Medicare population and make recommendations regarding an appropriate frailty adjuster for this population. Currently, the Program of All-inclusive Care for the Elderly (PACE) demonstration projects receive a frailty adjuster of 2.39. This project will determine whether this is an appropriate adjuster using data from the National Long-term Care Survey, the Medicare Current Beneficiary Survey, and DataPACE. The findings from this project will feed into the determination of the payment rates for PACE providers who will be receiving permanent provider status as of August 6, 1998.

Status: This project has just finished its design phase and is beginning to work on identifying differences across States in their definitions of nursing home certifiable. This information will be used to identify individuals who are nursing home certifiable on the data sets to be used in the project.

91-017 Evaluation of the Program of All-inclusive Care for the Elderly Demonstration

Project No.:	500-91-0027
Period:	June 1991-March 1997
Funding:	$4,486,514
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1986; Omnibus Budget Reconciliation Act of 1987; Omnibus Budget Reconciliation Act of 1990

Description: The Program of All-inclusive Care for the Elderly (PACE) Demonstration replicates a unique model of managed-care service delivery for 300 very frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes--as core services--the provision of adult day health care and multidisciplinary team case management through which access to and allocation of all health and long-term-care services are arranged. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. One purpose of the evaluation is to examine PACE sites before and after assumption of full financial risk, with the purpose of determining whether the PACE model of care, as a replication of the On Lok Senior Health Services model of care, is cost-effective relative to the existing Medicare and Medicaid programs. Another purpose is to examine the decision to enroll in PACE in order to understand how PACE enrollees differ from those who are eligible for PACE but refuse to enroll in the program; to determine the impact of PACE on participant health services utilization, expenditures, and outcomes; and to explore the subobjectives of PACE or the link between PACE and the outcomes of interest.

Status: Preliminary findings from the evaluation suggest the following:

- PACE reduces nursing home and hospital use, while increasing use of ambulatory and other non-institutional services.
- PACE is associated with improved health status, quality of life and satisfaction, though not with measurable improvement in physical function.
- PACE appears to be more effective at reducing institutional utilization and improving health status and satisfaction for participants with high levels of

physical impairment than for the less impaired.

Further evaluation findings will be produced as part of project number 97-016 (described below).

97-016 Evaluation of the Program of All-inclusive Care for the Elderly

Project No.:	500-96-0003/04
Period:	April 1997-July 1998
Funding:	$1,026,292
Award:	Task Order
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Nancy Miller, Ph.D. Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1986

Description: The Evaluation of the Program of All-inclusive Care for the Elderly (PACE) consists of both qualitative and quantitative components. The purpose of the qualitative component is to examine, in detail, the structure and process of case management as well as gain a better understanding of the factors that drive interdisciplinary team decisionmaking in the PACE model. Since enrollment in PACE has been lower than originally expected, except for On Lok, the first part of the quantitative part of the evaluation of PACE is examining the decision to participate in PACE. This is particularly important given the anomaly of under-enrollment in virtually all long-term care alternatives, as well as the policy interest in encouraging increased use of managed care. In the evaluation, the process by which people come to participate in PACE is modeled. The "refusers" or those who apply to PACE and pass the initial screening eligibility criteria but do not actually enroll in the program serve as the comparison group for the evaluation of the impact of PACE. The impact evaluation of PACE is addressing a broad range of questions including:

- Does the government spend less on PACE clients than it would have spent on them in the absence of PACE?
- Does the PACE program spend no more on PACE clients than the capitation amount?
- Does PACE alter the mix of services provided?
- Does the quality of life and satisfaction with services increase for participants and family member?
- Does PACE impact the presence and amount of formal in-home care, formal care outside the home, informal in-home care and informal care outside the home?
- How does PACE affect the health status and functional status of PACE participants?

Status: All of the data collection for this project has been completed. Currently, the contractor is in the process of analyzing the impact of PACE on Medicare costs. Over the next few months we will be receiving reports regarding how case management works in PACE and how PACE affects Medicare spending.

COMMUNITY NURSING ORGANIZATION DEMONSTRATION

Mandates:	Omnibus Budget Reconciliation Act of 1990; Balanced Budget Act of 1997

Description: Section 4079 of the Omnibus Budget Reconciliation Act of 1990 directs the Secretary of Health and Human Services to conduct demonstration projects at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the Community Nursing Organization (CNO) Demonstration are capitated payment and nurse case management. These two elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute-care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. Four applicants were awarded site demonstration contracts on September 30, 1992. The selected sites represent a mix of urban and rural sites and different types of health providers, including a home health agency, a hospital-based system, and a large multispecialty clinic. The four sites are identified below.

Status: All four CNO demonstration sites have undergone a 1-year development period and began a 3-year operational period in January 1994. The Balanced Budget Act of 1997, extends the demonstration period through December 31, 1999. Abt Associates, Inc. was

selected to evaluate the project and to provide technical assistance to the four CNO sites. Abt Associates, Inc. also was awarded the external quality assurance contract

92-070 **Community Nursing Organization Demonstration: Carle Clinic Association**

Project No.:	500-92-0053
Period:	September 1992-June 1998
Funding:	$1,786,629
Award:	Contract
Principal Investigator:	Cheryl Schraeder, Ph.D.
Awardee:	Carle Clinic Association 307 East Oak, Suite 3 P.O. Box 718 Mahomet, IL 61853
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

92-071 **Community Nursing Organization Demonstration: Carondelet Health Services, Inc.**

Project No.:	500-92-0055
Period:	September 1992-June 1998
Funding:	$878,413
Award:	Contract
Principal Investigator:	Gerri Lamb, Ph.D.
Awardee:	Carondelet Health Services, Inc. Carondelet St. Mary's 1601 West St. Mary's Road Tucson, AZ 85745
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

92-072 **Community Nursing Organization Demonstration: Living at Home/Block Nurse Program**

Project No.:	500-92-0052
Period:	September 1992-June 1998
Funding:	$193,938
Award:	Contract
Principal Investigator:	Linda Robertson
Awardee:	Living at Home/Block Nurse Program Ivy League Place, Suite 225 475 Cleveland Avenue North St. Paul, MN 55104
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

92-073 **Community Nursing Organization Demonstration: Visiting Nurse Service of New York**

Project No.:	500-92-0054
Period:	September 1992-June 1998
Funding:	$945,282
Award:	Contract
Principal Investigator:	Ruth Mitchell
Awardee:	Visiting Nurse Service of New York 107 East 70th Street New York, NY 10021-5087
HCFA Project Officer:	Thomas Theis Center for Health Plans and Providers

94-038 **Community Nursing Organization Demonstration External Quality Assurance**

Project No.:	500-92-0014/04
Period:	June 1994-June 1998
Funding:	$535,304
Award:	Delivery Order
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Melissa Hulbert, M.P.S. Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1987

Description: The purpose of this project is to conduct an external review of the quality of health care delivered to Medicare beneficiaries participating in the CNO demonstration (a risk-reimbursed coordinated care program for home health and selected ambulatory services). The CNO Demonstration External Quality Assurance project includes a quarterly review of client medical records for a sample of clients receiving Medicare-covered mandatory CNO services, and a quarterly review of CNO assessments and provision of CNO interventions on a sample of all enrollees. Under this project, the awardee is responsible for monitoring the quality of care management and health education

services provided through the CNO and implementing corrective actions, when necessary. The quality of traditional Medicare home health services is being monitored. The awardee also conducted a use review of the home health services provided to enrollees to validate or support changes in capitation payment rates. The evaluation contractor is being provided with documentation of the findings and interventions of the quality assurance process.

Status: Quality reviews are being conducted.

92-068 Evaluation of the Community Nursing Organization Demonstration

Project No.:	500-92-0050
Period:	September 1992-June 1998
Funding:	$3,014,634
Award:	Contract
Principal Investigator:	Robert J. Schmitz, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Melissa Hulbert, M.P.S. Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1987

Description: The Community Nursing Organization (CNO) Demonstration was mandated by section 4079 of the Omnibus Budget Reconciliation Act of 1987. The legislation directs the Secretary of the Department of Health and Human Services to conduct a demonstration project at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the CNO are capitated payment and nurse case management. These two elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. The CNO sites receive a monthly capitation payment for each enrollee. The capitation rate is modeled on the average adjusted per-capita cost-payment method used for Medicare health maintenance organizations. The CNO per-capita payment rate will be set at a level that is equal to 95 percent of the adjusted average per-capita Medicare payment for community and ambulatory services in the CNO's geographic area. The legislation mandates the use of two types of CNO per-capita payment methods. Payment Method A adjusts the per capita payment according to an individual's age, gender, and prior home health use. Payment Method B adjusts the per capita payment according to an individual's functional status in addition to age, gender, and prior home health use. The evaluation of the CNO demonstration will test the feasibility and effect on patient care of a capitated, nurse case-managed service-delivery model. Both qualitative and quantitative components are included in the evaluation design. The qualitative component will use a case study approach to examine the operational and financial viability of the CNO model. The quantitative component will use a randomized design to measure the impact of the CNO intervention on mortality, hospitalization, physician visits, nursing home admissions, and Medicare expenditures, as well as on such nurse-sensitive outcomes as knowledge of health problems and management of care.

Status: The four CNO demonstration sites completed a developmental period and began the operational period in January 1994, and collection of baseline data for CNO enrollees began immediately. Site visit reports summarizing site activities have been completed. An interim report was prepared and a second interim report was expected in spring 1997. However, the sites requested further analyses be added. This report is now expected in March 1998.

95-089 State of Minnesota "Senior Health Options Project"

Project No.:	11-W-00024/5
Period:	April 1995-December 2000
Award:	Waiver-only Project
Principal Investigator:	Pamela Parker
Awardee:	Minnesota Department of Human Services Human Services Building 444 Lafayette Road St. Paul, MN 55155
HCFA Project Officer:	Melissa Hulbert, M.P.S. Office of Strategic Planning

Description: In April 1995, the State of Minnesota was awarded Medicare and Medicaid waivers for a 5-year demonstration designed to test delivery systems that integrate long-term care and acute-care services for elderly dual eligibles. The State targeted the elderly dually entitled population that resides in the 7-county metro area and St. Louis county. Elderly Medicaid eligibles now required to enroll in the State's current section 1115 Prepaid Medical Assistance Program (PMAP) demonstration are being given the option to enroll in the Senior Health Options (SHO) Project, which in essence adds long-term care and Medicare benefits to basic PMAP benefits. Under this demonstration, the State is being treated as a health plan that contracts with HCFA to provide services, and provides those services through subcontracts with various appropriate providers. The State is continuing its current administration of the Medicaid-managed care program while incorporating some Medicare requirements that apply directly to the health plans with which the State would subcontract for SHO. HCFA's direct oversight functions will continue to apply to the overall demonstration and managing entity, which will be the State.

Status: The State implemented the project in March 1997.

94-089 **MAINE-NET: Medicaid- and Medicare-Managed Care for the Elderly and Physically Disabled in Maine**

Project No.:	11-C-90437/1
Period:	September 1994-April 1998
Funding:	$944,940
Award:	Cooperative Agreement
Principal Investigator:	Carreen Wright
Awardee:	Maine Department of Human Services Bureau of Medical Services State House Station No. 11 Augusta, ME 04333
HCFA Project Officer:	Kay Lewandowski Office of Strategic Planning

Description: This project is designing a demonstration of integrated models for the financing and delivery of managed health care and social services for Medicare and Medicaid elderly and physically disabled persons in Maine. The project seeks to promote the development of regional service delivery networks or health plans, particularly in rural areas of the State that would be responsible for the management, coordination, and integration of services, including multidisciplinary approaches to care planning and service delivery. The demonstration will provide a comprehensive package of primary, acute, and long-term-care institutional and noninstitutional services as part of a prepaid-capitated health plan for the target populations. The demonstration seeks to expand upon nursing home quality indicators developed in the HCFA-sponsored Multistate Case-Mix Demonstration Project and incorporate HCFA's quality assurance guidelines for managed care plans. In addition, the project will develop and use an activity of daily living-based case-mix adjustment for long-term-care services in the construction of capitation payment rates, using the Resource Utilization Group, Version III, classification system also developed in the multistate demonstration project. For services provided in boarding homes and in the community, two new case-mix methodologies will be developed for use by the demonstration.

Status: During the first year of the project, a concept paper describing the State's health care environment and the challenges facing the proposed demonstration program was drafted. In addition, an analysis of the cost and use patterns of State elderly and disabled Medicare and Medicaid beneficiaries was undertaken. During the second year, a request for information was created and issued, and the responses were reviewed by the State. The data from these responses, along with a detailed county-by-county environmental analysis formed the criteria used for the selection of two sites for the proposed demonstration. The State has submitted an application for demonstration waivers to HCFA; the application is under review.

98-202 **Multi-State Dual Eligible Database and Analysis Development**

Project No.:	500-95-0047/03
Period:	September 1997-September 2000
Funding:	$350,000
Award:	Task Order
Principal Investigator:	
Awardee:	Mathematica Policy Research, Inc. 101 Morgan Lane Plainsboro, NJ 08536
HCFA Project	William D. Clark

Officer: Office of Strategic Planning

Description: This project will use available Medicare/Medicaid-linked statewide data in 10-12 States to develop a uniform database that can be used by States and the Federal Government to improve the efficiency and effectiveness of the acute and long term care services to persons eligible for both Medicare and Medicaid (dual eligible). It will also conduct analyses derived from these data to strengthen the ability to develop risk-adjusted payment methods and deepen the understanding of Medicare-Medicaid program interactions as they relate to access, costs and quality of service. Finally, it will recommend longer range options that will improve the usefulness of the database for operational and policy purposes.

Status: The project is in its early start-up phase.

97-218 **Multi-State Evaluation of Dual Eligibles Demonstrations**

Project No.:	500-96-0008/03
Period:	September 1997-September 2002
Funding:	$1,000,000
Award:	Task Order
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	University of Minnesota 420 Delaware Street, SE. Minneapolis, MN 55455-0392
HCFA Project Officer:	Noemi Villafranca Office of Strategic Planning

Description: This evaluation is designed to assess the impact of dual eligible demonstrations in the States of Minnesota, Colorado, Wisconsin and New York. Analyses will be conducted for each State and across States. The quasi-experimental design will utilize surveys, case studies, and Medicare and Medicaid data for analysis. Major issues to be examined include the use of a capitated payment strategy to expand services while reducing/controlling costs, the use of case management techniques and utilization management to coordinate care and improve outcomes and the goal of responding to consumer preferences while encouraging the use of noninstitutional care. A universal theme to be developed is the difference between managing and integration.

Status: The Post Award Orientation Conference was held October 22, 1997. A draft of the updated evaluation design and updated management plan will be submitted in January 1998.

97-219 **Dual Eligible Research and Demonstration Data Development**

Project No.:	HCFA-97-0318
Period:	August 1997-August 1998
Funding:	$93,000
Award:	Purchase Order
Principal Investigator:	Dan Gilden
Awardee:	JEN Associates P.O. Box 39020 Cambridge, MA 02139
HCFA Project Officer:	William D. Clark Office of Strategic Planning

Description: The contractor is linking Medicare data for Colorado for the years 1989-1994 to Medicaid eligibility files for Mesa County. These data will be used for implementation of disability payment systems for the State's proposed Medicaid/Medicare demonstration. The contractor is also linking Wisconsin statewide Medicaid claims to Medicare National Claims History data for 1992-1995. These will be used for financial and rate-setting studies needed for implementaion of the under-65 disability payment systems for the State's Medicaid/Medicare demonstration. They are also conducting a technical study to determine the feasibility of transforming Massachusetts Medicaid claims into the Standard Medicaid Research File (SMRF) format since this is not a State that currently reports into the Medicaid Statistical Information System. This study will crosswalk Medicare data elements into the SMRF format. It is hoped that the results of this work will enable HCFA to determine the feasibility and costs of implementation (and full scale development) of a national database on dual eligibility.

Status: The project is underway.

97-224 **Dual Eligible Research and Demonstration Data Development**

Project No.:	HCFA-97-0395
Period:	September 1997-September 1998
Funding:	$24,955
Award:	Purchase Order

Principal Investigator:	Leonard Gruenberg
Awardee:	Data Chron Health Systems 763 Massachusetts Avenue, Suite 7 Cambridge, MA 02139
HCFA Project Officer:	William Clark Office of Strategic Planning

Description: The project is developing a nursing home certifiable (NHC) model for the under-65 disabled population. The contractor is analyzing data from the Medicare Current Beneficiary Survey for the Medicare population and the county Medicare Average Annual Per Capita Cost (AAPCC) data for the under-65 population and will develop an NHC factor for the frail elderly, and will propose a way for this factor to be incorporated into the Medicare AAPCC formula for the under-65 population. The analysis will include development of an NHC cost ratio for the under-65 population and a method for downgrading the cost ratios for the well population.

Status: The project is underway.

92-026 Special Care Managed Care Initiative

Project No.:	18-C-90127/5
Period:	February 1992-July 1998
Funding:	$656,270
Award:	Cooperative Agreement
Principal Investigator:	Howard Garber, Ph.D.
Awardee:	Wisconsin State Department of Health and Social Services 1 West Wilson Street P.O. Box 309 Madison, WI 53701-0309
HCFA Project Officer:	Melissa Hulbert, M.P.S. Office of Strategic Planning

Description: The purpose of the special care initiative project is to gain improved understanding of the need, use, and cost of delivery of health services to high-risk, severely disabled persons. The severely disabled population is a significant user of medical services. Moreover, cost between 1988 and 1991 increased at a rate double that of population increase. Therefore, an important objective is to contain the cost and use of Medicaid services by severely disabled persons, while maintaining or improving the level of client satisfaction.

Special Care, Inc. (SCI) is an independent, nonprofit organization that represents a joint venture between the Milwaukee Center for Independence, a Milwaukee rehabilitation facility, and the Wisconsin Health Organization, an established health maintenance organization. SCI provides specialized services, including a dedicated physician panel, case-management services, and clinical services as strategies to assess medical need and to better coordinate service resources available in the community. The State of Wisconsin uses a capitation methodology for reimbursement to SCI. Enrollment of SCI members is voluntary.

As a research and demonstration program, this project aims to improve the understanding of the need, use, costs, and cost-management opportunities associated with the delivery of health services to high-risk, severely disabled persons. These individuals are disabled, categorically needy, noninstitutionalized, exempt from the spenddown provisions, eligible for Medicaid, and eligible for Supplemental Security Income disability benefits.

To measure the performance of the SCI program, a management information system (MIS) file was created to match the demographic characteristics of program participants with the cost and use data obtained from the history files maintained by the Wisconsin Medicaid program. Medicaid data included service and procedure frequencies, service mix, billings and reimbursements, provider practices, and certain medical status indicators. MIS files contributed additional information on disability condition, enrollment information, benefit coordination, and case management. In addition, data on client satisfaction, quality of care, and enrollment/disenrollment decisions were collected.

Status: The State is operating this project under a section 1915(a) State plan exception. The program officially began in June 1994. As a point of clarification, Special Care signifies the initiative proposed to HCFA for the managed care program, while Independent Care (I Care) is the formal community name of the managed care company. In July 1996, a no-cost extension was granted to the State to allow for a full 3-year operational period.

An evaluation contract with the Human Services Research Institute (HSRI) was signed in May 1994 and HSRI conducted a 3-year evaluation, which combined survey data with HCFA's Medicaid Statistical

Information System Administrative files.

96-075 **Managed Care System for Disabled and Special Needs Children: District of Columbia**

Project No.:	11-W-00021/3
Period:	December 1995-November 1998
Award:	Waiver-only project
Principal Investigator:	Paul Offner
Awardee:	District of Columbia Department of Human Services Commission on Health Care Finance Suite 302 2100 Martin Luther King Jr. Ave., SW. Washington, DC 20020
HCFA Project Officer:	Phyllis A. Nagy Center for Medicaid and State Operations

Description: In December 1995 the District of Columbia was awarded a section 1115 Medicaid waiver to test the efficacy of a managed-care service delivery system designed for disabled and special needs children. Participants in the demonstration are children and adolescents who are under the age of 22, are eligible for Supplemental Security Income (SSI) payments (i.e., considered disabled according to SSI guidelines), and are subsequently eligible for Medicaid as well.

The District of Columbia hopes to use the program to eliminate both barriers to access and other health care delivery problems that children who are disabled and their families encounter in the current Medicaid fee-for-service program. This managed-care program seeks to improve the health status and quality of life for these children, while reducing the overall health care costs associated with their care. Enrollment in the demonstration is voluntary; however, eligible children who do not explicitly choose to remain in the current fee-for-service system after being informed of the new program are assigned to Health Services for Children with Special Needs, Inc. (HSCSN) after a specified notice period. Enrollment cannot be finalized, however, until a health needs assessment is completed for each new member. Health services under this demonstration are being coordinated by HSCSN, a non-profit corporation established specifically for the purpose of providing managed care for children enrolling in the demonstration.

Status: The project was implemented in December 1995. As of November 1997, approximately 1,900 of the 3,000 eligible children have chosen to enroll in HSCSN, while approximately 500 children/families have chosen to remain in the fee-for-service system.

96-076 **Evaluation of the District of Columbia's Demonstration Project: Managed-Care System for Disabled and Special Needs Children**

Project No.:	500-96-0003/03
Period:	September 1996-March 2000
Funding:	$1,203,963
Award:	Contract
Principal Investigator:	Carol Irvin, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Paul W. Eggers, Ph.D. Office of Strategic Planning

Description: The District of Columbia submitted a waiver-only request for Medicaid waivers under section 1115(a)(1) for a 3-year demonstration project to test the efficacy of a managed care service delivery system designed for children and adolescents under the age of 22 who are eligible for Medicaid and are considered disabled according to Supplemental Security Income (SSI) Program guidelines. This study represents a unique opportunity to examine the experiences of a managed-care system with voluntary enrollment of children with disabilities. The project, which seeks to integrate acute and long-term-care services for children with disabilities into a single capitated payment methodology, is the first approved demonstration of its kind. The information gathered will be used to inform both State and Federal policymakers who have increasingly come to regard managed care as a mechanism to contain growing health care expenditures. This study will provide for a special analysis of the enrollment and disenrollment processes, as well as of the project's implementation process (including enrollment and participation, services/benefits, provider participation and training, organizational and administrative issues, contracting and risk-sharing arrangements, provider fee schedules, community involvement, and quality assurance, administrative and data management systems). Outcome analyses will focus on enrollee/family outcomes (including care management, service utilization and

costs, enrollee/family satisfaction, quality of care and health status indicators, access to care, and family/informal care giving), organizational outcomes (including an analysis of Health Services for Children with Special Needs, Inc.'s (HSCSN) financial performance, and the risk sharing arrangements between HSCSN and the District of Columbia), and the impact upon the provider community. Data for the evaluation will come from surveys (primary data collection), case study interviews, focus groups, Medicaid Management Information System and encounter data, and SSI data.

Status: Analytic plans have been developed, focus groups have been conducted and data are being developed. Clearance of a caregiver survey (as required by the Paperwork Reduction Act) was underway as of the end of December 1997.

97-027 **Barriers and Other Correlates of Health Care Practices Associated With Selected Precursors of End Stage Renal Disease among At-Risk African Americans: Exploring and Intervening for Change**

Project No.:	20-C-90860/4
Period:	September 1997-September 1999
Funding:	$94,840
Award:	Cooperative Agreement
Principal Investigator:	Ivor Lenworth Livingston
Awardee:	Howard University 2400 6th, NW. Washington, DC 20059
HCFA Project Officer:	Richard Bragg Office of Strategic Planning

Description: The objectives of the study are to:

- Explore and assess the relationship of barriers, and other correlates of desirable health care practices engaged in by at-risk African Americans, related to End Stage Renal Disease (ESRD) and its two precursors (diabetes mellitus and hypertension).
- Assess the effectiveness of selected educational intervention strategies at the micro level, i.e., involving public housing residents in improving health care practices of African Americans related to ESRD and its two selected precursors.
- Determine the wider societal impact (in the surrounding communities around designated public housing sites), if any, of selected educational intervention strategies in reducing the frequency of ESRD treatment cases, and its related outcomes (e.g., ESRD-related deaths).

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

97-028 **Prevalence of Key Health Risk Factors and Barriers to Health Care Seeking among Medicaid and Medicare Eligible Living In Low Income Housing Projects**

Project No.:	20-C-90841/4
Period:	September 1997-September 1999
Funding:	$124,984
Award:	Cooperative Agreement
Principal Investigator:	Margaret K. Hargreaves
Awardee:	Meharry Medical College 1005 DBTodd Boulevard Nashville, TN 37208
HCFA Project Officer:	Richard Bragg Office of Strategic Planning

Description: The purposes of the study are to assess health status and identify risk factors relating to the three leading causes of death, cardiovascular disease, cancer, and stroke as well as to determine barriers to access and utilization of health care among Medicare and Medicaid eligible population living in low income housing. The study will address the determinants of the differential of health problems in the African American community, describe the problems in access and quality involving health care services, and demonstrate an understanding of the socioeconomic and racial differences in health services. The study also will estimate the needs of these populations and explore the enabling factors that may enhance access and utilization of the existing health care system.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

96-213 **The Effects of Health Education on the Participation of African American Men in Routine Screening for Prostate Cancer in Rural Southwest Mississippi**

Project No.: 20-C-90718/4
Period: September 1996-September 1998
Funding: $283,011
Award: Cooperative Agreement
Principal Investigator: Leroy Davis
Awardee: Alcorn State University
1000 ASU Drive #210
Lorman, MS 39096
HCFA Project Officer: Richard Bragg
Office of Strategic Planning

Description: The purpose of this study is to increase the level of understanding of African-American males and their families about prostate cancer and prostate health. The level of understanding is operationally defined as changes in the relationships among knowledge, attitudes, and behaviors. It is expected that, at the end of this study, participants will demonstrate an increased level of understanding of prostate cancer and prostate health and the importance of routine screening as a result of health education. The objectives are as follows:

- To increase the knowledge level of African American men about prostate health and prostate cancer as measured by pre- and post-tests.
- To change the attitude of the African American men toward prostate cancer and prostate health, as measured by pre- and post-survey data.
- To change the behavior of African American men in relation to routine screening for prostate cancer by increasing the number who participate in regular and systematic screening over a 2-year period.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

97-026 An Awareness Program to Empower Decisionmaking About Prostate Cancer among African American Males: An Urban and Rural Initiative

Project No.: 20-C-90853/3
Period: September 1997-September 1999
Funding: $123,482
Award: Cooperative Agreement
Principal Investigator: Virginia J. Smith
Awardee: Lincoln University
3020 Market St., 2nd Floor
Philadelphia, PA 19104
HCFA Project Officer: Richard Bragg
Office of Strategic Planning

Description: The objectives of the study are to:

- Increase awareness of issues relating to prostate cancer screening and treatment among and including up to 4,400 African American adults in two target areas (urban Philadelphia, Pennsylvania, and rural areas of the State of Delaware).
- Demonstrate improved feelings of empowerment for decisionmaking about prostate cancer screening and treatment.
- Provide information on comparison data on outcomes of an educational intervention program on prostate cancer for a group of rural and urban African American adults.
- Test training materials to prepare lay trainers for empowerment training at the community level in the African American community.
- Test training materials for dissemination to the African American community, designed to improve decisionmaking skills about prostate cancer screening and treatment.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

96-069 Determinants of Barriers to Minority Access to Health Care and Differential Health Care Utilization Between Older African Americans and Caucasians

Project No.: 20-C-90721/3-02
Period: September 1996-September 1998
Funding: $168,932
Award: Cooperative Agreement
Principal Investigator: Thomas Obisesan
Awardee: Howard University Hospital
2041 Georgia Avenue, NW.
Washington, DC 20060
HCFA Project Officer: Richard Bragg
Office of Strategic Planning

Description: The objectives of this proposal are:

- To examine the differences in health status and socioeconomic status of elderly African Americans, determining how these factors influence their use of health and long-term-care services.
- To investigate the combined influences of informal support networks and formal health care programs in the lives of the African American elderly, and how these factors influence nursing home placement and mortality.
- To examine the assumption that, as a minority group member, the African American elderly receive more support from their informal networks than non-minority elderly.

The focus of the study will be to examine the health utilization and outcomes for these two groups over a 4-year period.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

96-070 **The Effects of Health Education on the Participation of African American Men in Routine Screening for Prostate Cancer in Rural Southwest Mississippi**

Project No.:	20-C-90718/4-01
Period:	September 1996-September 1998
Funding:	$291,011
Award:	Cooperative Agreement
Principal Investigator:	Frances Henderson and Leroy Davis
Awardee:	Alcorn State University 1000 ASU Drive, #210 Lorman, MS 39096
HCFA Project Officer:	Richard Bragg Office of Strategic Planning

Description: The purpose of this study is to increase the level of understanding of African-American males and their families about prostate cancer and prostate health. The level of understanding is operationally defined as changes in the relationships among knowledge, attitudes and behaviors. It is expected that, at the end of this study, participants will demonstrate an increased level of understanding of prostate cancer and prostate health and the importance of routine screening as a result of health education. The objectives are:

- To increase the knowledge level of African American men about prostate health and prostate cancer as measured by pre- and post-tests.
- To change the attitude of the African American men toward prostate cancer and prostate health, as measured by pre- and post-survey data.
- To change the behavior of African American men in relation to routine screening for prostate cancer by increasing the number who participate in regular and systematic screening over a 2-year period.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

96-072 **Oral Rehydration Therapy and Children Immunization Initiatives for Infants and Children of AFDC Beneficiaries from Inner-City African American Communities**

Project No.:	20-C-90706/3-02
Period:	September 1996-September 1998
Funding:	$319,834
Award:	Cooperative Agreement
Principal Investigator:	Anna McPhatter
Awardee:	Morgan State University Coldspring Lane and Hillen Road Baltimore, MD 21239
HCFA Project Officer:	Richard Bragg Office of Strategic Planning

Description: The goal of this collaborative research effort of Morgan, Coppin State, and Norfolk State Universities is to design, implement, and evaluate a community-based self-help demonstration health project aimed at increasing the awareness and utilization of immunization against common childhood diseases and oral rehydration therapy (ORT) for diarrheal disease treatment among 225 targeted African American families of Aid to Families with Dependent Children beneficiaries. This is a demonstration project with three goals:

- To increase the immunization rate among its participants to 80 percent.
- To increase the use of oral rehydration therapy from 0 percent to 30 percent.
- To enhance the knowledge of ORT among child care and health care providers.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

96-071 **The Use of Educational Intervention Programs in African American Communities to Decrease the Racial Disparity in Access to and Utilization of Heart and Vascular Procedures**

Project No.:	20-C-90716/3-01
Period:	September 1996-September 1998
Funding:	$175,622
Award:	Cooperative Agreement
Principal Investigator:	Dorothy M. Mattison
Awardee:	University of Maryland Eastern Shore Department of Business and Economics Princess Anne, MD 21853
HCFA Project Officer:	Richard Bragg Office of Strategic Planning

Description: The project aims to reduce the racial differences in access and utilization of high-cost cardiovascular surgical procedures by Medicare beneficiaries. It involves an evaluation of the extent of prevailing racial differences and the development and implementation of an educational intervention. It will include developing and administering novel educational programs in local African American communities and identifying barriers to utilizing high quality, perhaps cost-efficient and vascular surgical procedures. Specifically, an analysis of African American Medicare beneficiary utilization rates of cardiovascular surgical procedures performed in the hospital will be done. A comparison will be made between the availability and utilization on the study procedures for African American and white Medicare beneficiaries. An education intervention is being utilized in the form of seminars and workshops conducted at senior citizen centers, churches, and civic and community organization meetings. The goal of this effort is to provide an awareness of treatment choices for specific heart and vascular conditions.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

96-073 **Mental Health Service Utilization by the Elderly in Tennessee: The Effect of Race, Social Class, and Comorbidity**

Project No.:	20-C-90705/4-02
Period:	September 1996-September 1998
Funding:	$197,852
Award:	Cooperative Agreement
Principal Investigator:	Baqar Husaini
Awardee:	Tennessee State University 3500 John Merritt Boulevard Nashville, TN 37209-1561
HCFA Project Officer:	Richard Bragg Office of Strategic Planning

Description: This 2-year collaborative project will examine the effects of race, socioeconomic status and comorbidity on utilization of mental health services by the elderly of Tennessee during 1989-92. This period for the analysis of Medicare data is chosen because it corresponds to the same time when two large multi-year surveys on randomly selected African American and white elderly of Nashville were conducted. The study would examine the role of social class, ethnicity, comorbidity, diagnosis, type of services and mortality among the mentally afflicted. Costs also will be included in the analysis. The specific objectives of the analysis are to determine the effect of race, social economic status (SES) (using education and income), and comorbidity on mental health service utilization including hospital and outpatient in Tennessee. It would determine the racial patterns of mental health service use by clinical diagnosis, examine the effect of comorbidities and SES on patterns of service utilization within each racial group, and determine the effect of comorbidity and SES on the cost of hospitalization by race.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

96-068 **Utilization of Mammography Services among Elderly African American Women: Educational Intervention and Research Project**

Project No.:	20-C-90707/4-02
Period:	September 1996-August 1998
Funding:	$245,276
Award:	Cooperative Agreement
Principal	

Investigator:	Augustine O. Agho
Awardee:	Florida Agricultural and Mechanical University Martin Luther King Boulevard Tallahassee, FL 32307
HCFA Project Officer:	Richard Bragg Office of Strategic Planning

Description: The purpose of this research/demonstration project is to implement an educational intervention program. The intervention is designed to increase the level of awareness among elderly African American women who are Medicare recipients regarding Medicare coverage for mammography screening and clinical breast examination. The intervention is also designed to increase their knowledge of the benefits of these services, thus increasing their utilization of these life-saving technologies. The research component is designed to:

- Identify two rural and two urban counties.
- Analyze HCFA's 1995 claims file and to develop baseline screening rate for Medicare beneficiaries in those counties.

Women in these counties will then receive intervention and changes in screening rates will be evaluated.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

96-074 **Technical Assistance Program on Accessing and Utilizing HCFA's Medicare/Medicaid Data for Historically Black Colleges and Universities' Faculty Members and Researchers**

Project No.:	360-96-90080
Period:	September 1996-October 1997
Funding:	$50,000
Award:	Contract
Principal Investigator:	Johnnie R. Jackson
Awardee:	Biotechnology and Environmental Services, Inc. 8401 Corporate Drive, Suite 270 Landover, MD 20716
HCFA Project Officer:	Richard Bragg Office of Strategic Planning

Description: The Technical Assistance Program on the Access and Use of HCFA's Medicare/Medicaid data contract is to enhance the capacity of Historically Black Colleges and Universities (HBCU) faculty members and researchers to participate in the broad array of HCFA program activities. Interested HBCU staff will be trained on accessing and utilizing Medicare and Medicaid data. The training will be for the awardees of the 1996 Historically Black Colleges and Universities Grants Program and other HBCU data users. Researchers will become familiar with HCFA data analyses in a problem-oriented learning environment. Training will be provided on an individual basis through consultative services, and a group session (15-20 persons) for a 2-day period. A hands-on data laboratory curriculum will be developed in conjunction with HBCU faculty and researchers' identified priorities.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

96-087 **Health Services Research Activities--Technical Assistance, Research, Information, Collaboration, Training, Networking, and Program Development for Historically Black Colleges and Universities**

Project No.:	HCFA-IA-95-130
Period:	September 1995-September 1998
Funding:	$500,000
Award:	Interagency Agreement
Principal Investigator:	Georgia Buggs
Awardee:	Office of Minority Health Office of Public Health and Science Rockwall II Building, Suite 1000 (10th Floor) 5600 Fishers Lane Rockville, MD 20857
HCFA Project Officer:	Richard Bragg Office of Strategic Planning

Description: The objectives of this interagency agreement are for HCFA to increase the research capacity of Historically Black Colleges and Universities (HBCU) to conduct health services research using HCFA data by:

- Developing ties between HBCU researchers and HCFA staff.

- Fostering inter-university communications regarding minority health care issues.
- Developing a Research Network among HBCUs.
- Encouraging researchers to work individually or collaboratively on promoting research aimed at developing a better understanding of African American health care service issues.
- Developing and/or enhancing the administrative infrastructure of participating Office of Sponsored Programs at 12 selected HBCUs to assist their institutions to develop the capacity to successfully compete for Federal/non-Federal funding.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

IM-047 **Inventory of Projects with Special Focus on African Americans and Other Minorities**

Funding:	Intramural
HCFA Project Director:	Richard Bragg Office of Strategic Planning

Description: The objectives of this project are as follows:

- To inventory HCFA research, evaluation, and demonstration projects to determine their effects on African Americans as related to health status, access to service, utilization, and out-of-pocket expenditures.
- To determine the participation of African-American populations in extramural and intramural research efforts related to the health care delivery service.
- To promote HCFA's research that will be aimed at developing a better understanding of health care services issues pertaining to African Americans.
- To prepare a compendium that emphasizes aforementioned activities.

Status: This project is under development.

IM-048 **Development Activities of the HBCU Network**

Funding:	Intramural
HCFA Project Director:	Richard Bragg Office of Strategic Planning

Description: Utilizing a networking system, the Historically Black Colleges and Universities (HBCU) are able to do the following:

- Channel health-related research information.
- Stimulate the need for culturally sensitive research.
- Provide technical assistance for addressing the unique health needs of African Americans and other minorities.
- Facilitate the cohesion of a strong core of researchers with experience in and sensitivity to health-related research on the black community.

The purposes of the HBCU Network are as follows:

- Develop and foster research on the health needs of African Americans and to help reduce differentials in health status between blacks and whites.
- Set priorities on health research needs in African-American populations.
- Encourage collaborative research by bringing together institutions and individuals concerned with increasing health-related research in African-American populations in order to create a regional, cultural mass of relevant expertise.
- Develop a coordinated program to increase the number of black health researchers.

Status: The project is under development.

95-073 **Evaluation and Technical Assistance of the Medicare Alzheimer's Disease Demonstration**

Project No.:	500-95-0015
Period:	May 1995-November 1997
Funding:	$802,642
Award:	Contract
Principal Investigator:	Robert J. Newcomer, Ph.D.
Awardee:	Institute for Health and Aging University of California 201 Filbert Street Box 0612, Laurel Heights San Francisco, CA 94133-0612
HCFA Project Officer:	Dennis M. Nugent Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1986 Omnibus Budget Reconciliation Act of 1990; Omnibus Budget Reconciliation Act of 1993

Description: The purpose of the Medicare Alzheimer's Disease Demonstration was to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive in-home and community-based services to beneficiaries who have dementia. Two models of care were studied under this project. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models varied by the intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month. Some questions to be addressed by the evaluation are as follows:

- What factors are associated with the impact on health status and the cost-effectiveness of providing an expanded package of home care and community-based services to Medicare beneficiaries with Alzheimer's disease or related disorders?
- How do the services provided under the demonstration affect the health status and functioning of dementia patients and their caregivers?
- What are the effects of providing home and community-based services on caregiver burden and stress?
- Do the home care and community-based services provided under the demonstration delay or prevent institutionalization of beneficiaries with dementia?

Status: The Medicare Alzheimer's Disease Demonstration was extended twice by congressional legislation. Because of the protracted length of the project, the original Evaluation and Technical Assistance contract expired prior to the completion of the evaluation. A new contract was awarded to enable the evaluator to complete its analysis and interpretation of the demonstration's primary and secondary data. The draft final report is expected in March 1998.

94-073 **Multistate Analysis of Utilization, Expenditures, and Access to Care for Persons with Acquired Immunodeficiency Syndrome**

Project No.:	500-92-0022/04
Period:	September 1994-April 1997
Funding:	$490,114
Award:	Delivery Order
Principal Investigator:	Craig Thornton, Ph.D.
Awardee:	University of Minnesota School of Public Health, Box 729 Minneapolis, MN 55455-0392
HCFA Project Officer:	Michael Kendix, Ph.D. Office of Strategic Planning

Description: The project conducted a study of persons with acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV)-related diseases. In particular, the project conducted a statistical investigation and examined trends in enrollment, service use, and expenditure patterns of Medicare and California Medicaid patients. It compared these programs and assessed differences in access to care. The project provided more expansive and current data on use and expenditures related to AIDS and HIV health services.

Status: The project is completed. The final report, "Methods of Identifying AIDS Cases in Medicare and Medicaid Claims Data," is available from the National Technical Information Service, accession number PB98-110562.

97-051 **Updating the Profile of Medicare Beneficiaries with AIDS**

Project No.:	500-97-0004
Period:	September 1997-September 1998
Funding:	$205,767
Award:	Contract
Principal Investigator:	Craig Van Thornton
Awardee:	Mathematica Policy Research P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Michael Kendix, Ph.D. Office of Strategic Planning

Description: The project will update data analyzing HCFA claims data for 1994, 1995, and 1996, with the objective of providing a longitudinal database for 1991 through 1996.

Status: This project is currently in the data collection stage.

93-210 **End Stage Renal Disease (ESRD) Study**

Project No.:	HCFA-IA-97-86
Period:	November 1992-June 1999
Funding:	$471,438
Award:	Interagency Agreement
Principal Investigator:	Lawrence Agodoa, M.D.
Awardee:	NIDDKD/University of Michigan Natcher Building, 6AS13B 45 Center Drive Bethesda, MD 20892-6500
HCFA Project Officer:	Joel W. Greer, Ph.D. Office of Strategic Planning

Description: This interagency agreement (IAA) continues to provided funds to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to cover the cost of having the coordinating center for the U.S. Renal Data System perform economic and cost-effectiveness studies. This relationship was begun under a 1993 IAA. NIDDK continues to contract with the University of Michigan to be the coordinating center. The IAA calls for the coordinating center to conduct cost or cost-effectiveness components for at least four existing data studies and for one special study focused on economic issues each year.

Status: This work is ongoing.

93-061 **Economic and Cost-Effectiveness Studies for the U.S. Renal Data System**

Project No.:	HCFA-IA-93-05
Period:	July 1993-June 1998
Funding:	$1,657,075
Award:	Interagency Agreement
Principal Investigator:	Philip J. Held, Ph.D.
Awardee:	National Institute of Diabetes and Digestive and Kidney Diseases c/o Larry Agadoa, M.D. Natcher Building, 6AS13B 45 Center Drive Bethesda, MD 20892-6500
HCFA Project Officer:	Joel W. Greer, Ph.D. Office of Strategic Planning
Mandates:	Omnibus Budget Reconciliation Act of 1986

Description: This interagency agreement (IAA) provided funds to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to cover the cost of having the coordinating center for the U.S. Renal Data System (USRDS) perform economic and cost-effectiveness studies. NIDDK contracted with the University of Michigan to be the coordinating center for 5 years. The IAA calls for the coordinating center to conduct cost or cost-effectiveness components for at least four existing data studies and for one special study focused on economic issues each year.

Status: The coordinating center created annual cost data sets. Two major ongoing studies were the (1) costs of providing dialysis based on dialysis facility annual cost report data and (2) cost-effectiveness study of vascular access techniques for hemodialysis. Sections on cost and cost effectiveness were published in the 1995, 1996 and 1997 USRDS Annual Data Reports. These reports are available from the National Technical Information Service. The accession number for the 1995 report is PB95-271391; the accession number for the 1996 report is PB97-111041; the 1997 report will be available from NTIS and is also on the web at http://www.med.umich.edu.usrds/. The final report for this period was being drafted as 1997 ended.

END STAGE RENAL DISEASE (ESRD) MANAGED CARE DEMONSTRATION

Description: At present, end stage renal disease (ESRD) patients cannot enroll in health maintenance organizations (HMO) under Medicare contracts, but may remain in if they develop ESRD after enrollment. The current ESRD capitation payment is State-specific, but unadjusted, and based on 95 percent of fee-for-service costs. Under the demonstration, rates will be paid on the basis of treatment status (maintenance dialysis, transplant episode, or functioning graft), and adjusted for patient age and whether diabetes was the cause of kidney failure. Demonstration rates are based on 100 percent of fee-for-service costs, and additional non-Medicare-covered benefits are to be provided.

The demonstration will test whether:

- Year-round open enrollment of Medicare's ESRD patients in managed care is feasible.
- Integrated acute and chronic care services, and case management for ESRD patients, improves health

outcomes.

- Capitation rates reflecting patients' treatment needs increases the probability of kidney transplant.
- The additional benefits are cost-effective.

The demonstration sites are described below.

96-083 ESRD Managed Care Demonstration: Health Options

Project No.:	95-C-90692/4
Period:	September 1996-September 2000
Award:	Cooperative Agreement
Principal Investigator:	Bruce Davidson, SVP
Awardee:	Health Options, Inc. Building 300, 3rd Floor 4800 Deerwood Campus Parkway Jacksonville, FL 32236-0729
HCFA Project Officer:	Bonnie M. Edington Office of Clinical Standards and Quality

Description: Health Options is an HMO with a Medicare risk contract. The demonstration program, Advanced Renal Options, will operate in Dade, Broward and Palm Beach counties, an area in which there are approximately 4,800 ESRD patients. Case managers will be hired by the HMO. Nephrologists, who will function as primary care physicians, will be paid a capitation rate. Dialysis facilities will be paid a global fee per treatment. Both nephrologists and dialysis facilities will be paid an incentive payment for achieving quality-related outcome targets. Extra benefits to be offered under the demonstration include a diabetes management program, prescription drugs, nutritional supplements, and transportation to dialysis. Out-of-area dialysis during travel will be covered for up to 30 days annually.

Status: As of November 1997, contracts were being developed for the demonstration with nephrologists, dialysis facilities, and hospitals, including a transplant facility. Implementation is expected in February 1998.

96-086 ESRD Managed Care Demonstration: Phoenix Healthcare of Tennessee

Project No.:	95-C-90696/4
Period:	September 1996-September 2000
Funding:	$150,000
Award:	Cooperative Agreement
Principal Investigator:	Anica Howard
Awardee:	Phoenix Healthcare of Tennessee 3401 West End Ave., Suite 470 Nashville, TN 37203
HCFA Project Officer:	Bonnie M. Edington Office of Clinical Standards and Quality

Description: Phoenix Healthcare of Tennessee is a State-licensed HMO that has applied for a Medicare risk contract. The service area for the demonstration consists of 40 counties surrounding Nashville, an area containing approximately 1,400 ESRD patients. However, initially, the service area for the demonstration will be the 5-county core in the Medicare contract area. Case managers will be hired by the HMO. Dialysis clinics will be paid a fixed rate incorporating payment for ancillary services as well as dialysis. Nephrologists will be paid a capitation rate that is to cover inpatient as well as outpatient services. Phoenix may pay bonuses to nephrologists and dialysis facilities if specific quality criteria are met. Extra benefits to be offered under the demonstration may include an introductory home visit, certain preventive health services, transportation to dialysis, nutritional supplements, and some prescription and over-the-counter drugs.

Status: For the demonstration, Phoenix has signed contracts with most of the nephrologists in the service area, and agreements have been finalized with dialysis facilities and hospitals, including one transplant facility. Agreements are being negotiated with additional hospitals, and other providers may be added. Implementation is expected to begin in April 1998.

Managed Care End Stage Renal Disease

96-084 ESRD Managed Care Demonstration: Kaiser Foundation Health Plan--Southern California

Project No.:	95-C-90695/9
Period:	September 1996-September 2000
Funding:	$175,000
Award:	Cooperative Agreement
Principal Investigator:	Melodi Shapiro
Awardee:	Kaiser Foundation Health Plan, Inc. 815 Colorado Blvd., Suite 108 Los Angeles, CA 90041

HCFA Project Officer:	Bonnie M. Edington Center for Medicaid and State Operations

Description: Kaiser-Permanente Southern California Region (KPSCR) is a not-for-profit, group practice HMO with a Medicare risk contract. Their proposed service area for the demonstration is in Los Angeles, Orange, San Bernardino, Riverside, and San Diego Counties, an area in which there are approximately 13,000 ESRD patients. Prior to implementation of the demonstration, KPSCR had more than 2,000 ESRD patients who had developed ESRD after they were enrolled in the HMO. Under the demonstration, KPSCR will build on its case management model, integrating a diabetes education coordinator into the team, and incorporating more social work, nutritional monitoring, pharmaceutical, and quality of life services. Most non-dialysis care will be provided at existing Kaiser Permanent Facilities. Transplant services will be provided at UCLA and UCSD medical centers. In the first year of the demonstration, community nephrologists and dialysis facilities are to be given an incentive payment for uniform reporting of data. Additional benefits under the demonstration include: enhanced health education and family supportive services, and nutritional supplements. Out-of-area dialysis during travel will be covered for up to 60 days annually.

Status: Implementation of the demonstration began in December 1997.

94-103 Medicare End Stage Renal Disease Capitation Demonstration Technical Assistance Contract

Project No.:	500-94-0043/02
Period:	September 1994-September 1997
Funding:	$499,444
Award:	Delivery Order
Principal Investigator:	Stanley Wallack, Ph.D.
Awardee:	Brandeis University 415 South Street Waltham, MA 02254-9110
HCFA Project Officer:	Bonnie M. Edington Office of Clinical Standards and Quality

Description: The purpose of this contract was to assist HCFA in developing the end stage renal disease (ESRD) Managed Care Demonstration. The contractor also had a subcontract with Boston University for these purposes.

In October 1995, under this contract, an announcement of the demonstration was sent to all dialysis and kidney transplant facilities, all health maintenance organizations with a Medicare contract, and all insurance companies with a Medicare contract. The *Federal Register* Notice for the ESRD Managed Care Demonstration was published January 26, 1996; the Request for Proposal (RFP) was mailed to all requesters on February 29; proposals were received by May 17; and awards were made September 24 to: Health Options in Florida (see 96-083); Kaiser Foundation Health Plan (see 96-084); and Phoenix Healthcare of Tennessee (see 96-086). The contractor worked with HCFA in making site visits and providing technical assistance to the sites during the 1-year planning and development phase, prior to service delivery. The contractor provided information to HCFA for the development of an interim report to Congress.

Status: The contract ended September 30, 1997.

97-022 End Stage Renal Disease Capitation Demonstration, Evaluation

Project No.:	500-95-0059/03
Period:	August 1997-May 2002
Funding:	$1,425,046
Award:	Task Order
Principal Investigator:	Robert J. Rubin, M.D.
Awardee:	Lewin-VHI, Inc. 9302 Lee Highway, Suite 500 Fairfax, VA 22031-1214
HCFA Project Officer:	Michael Kendix, Ph.D. Office of Strategic Planning

Description: The project will use survey, claims and medical records data to evaluate the efficacy and cost effectiveness of permitting Medicare beneficiaries with end stage renal disease to enroll in managed care.

Status: The project is underway.

97-002 Medicaid Quality of Care (QC): Linked Medical Records, Eligibility and Claims File

Project No.:	500-96-0516/03

Period:	January 1997-July 1998
Funding:	$78,981
Award:	Task Order
Principal Investigator:	Celia H. Dahlman
Awardee:	CHD Research Associates, Inc. 5515 Twin Knolls Road, No. 322 Columbia, MD 21045
HCFA Project Officer:	M. Beth Benedict, Dr.P.H. Office of Strategic Planning

Description: This project is part of HCFA's research initiative on Medicaid Quality of Care. It is an extension of the Medical Records Study portion of this project. The work involves linkage of the medical record files with Medicaid enrollment and claims files. These files include Medicaid and privately-insured data sets. The analyses will include utilization and expenditure rates before and after pivotal clinical events.

Status: Files have been linked for one sample and analyses conducted. Additional linkages and analyses are being conducted.

93-076 Examination of the Medicaid Expansions for Children

Project No.:	500-93-0042
Period:	September 1993-March 1998
Funding:	$648,416
Award:	Contract
Principal Investigator:	Genevieve Kenney and Lisa Dubay
Awardee:	Urban Institute, The 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Paul W. Eggers, Ph.D. Office of Strategic Planning

Description: This project focuses on Medicaid eligibility expansions for children. These expansions were legislated as part of the Omnibus Budget Reconciliation Acts of 1989 and 1990. Analyses on the impact of the expansions include examination of enrollment and expenditure trends from 1988 to 1992; assessment of the extent to which the expansions penetrated the target population; and multivariate analysis to examine the impact of State policies and the eligibility group on enrollment, expenditures, and utilization of services. Steps to examine access to care and utilization of services include the development of a theoretical model, an analysis plan, and items that could be incorporated into an established national survey.

Status: The following tasks have been completed or begun:

- A review of proposed health reform bills and how they affect children.
- A report entitled, "Toward Evaluating the Effects of the Medicaid Eligibility Expansions on Low-Income Children's Access to Care and Service Use." This report outlines a theoretical model of children's health care use and uses the theoretical model to identify data that would be required to evaluate the effects of the Medicaid policy expanding eligibility to low-income children on their access to care and service use.
- A report, "The Effects of Medicaid Expansions on Insurance Coverage of Children," consists of an analysis of changes in insurance coverage using the Urban Institute's TRIM2 micro-simulation model. The report was published in *The Future of Children*, Volume 6, Number 7 (Spring 1996). Enrollment and expenditure tables for 1987 and 1992 for the four Tape-to-Tape States of California, Georgia, Michigan, and Tennessee and for the five SMURF States of Alabama, Kansas, Kentucky, Utah and Washington have been produced. In addition, enrollment and expenditures tables were produced for 1992 for Maine, Missouri, and New Jersey. The data contained in these tables are being used to conduct descriptive analyses that will assess enrollment and expenditure patterns over time and across enrollment groups. Project staff are currently writing reports based on these descriptive analyses.
- Data file construction and variable specification for individual-level multivariate models of health care expenditures, access, and utilization for children is almost complete. Project staff will be conducting these multivariate analyses in the coming months and producing papers describing the findings.

Finally, preliminary data analysis has been completed that use the Urban Institute's TRIM2-edited version of the Current Population Survey (CPS) to assess whether States' attempts to streamline the Medicaid eligibility process have lead to higher participation rates among Medicaid eligible children. Project staff have also begun an analysis using the TRIM2-edited CPS to assess the

extent to which the Medicaid expansions had "spillover" effects whereby older children with younger siblings covered by the expansions became uninsured when families dropped private insurance coverage to take up Medicaid coverage.

96-054 **Multi-State and Longitudinal Cohorts of Medicaid Children: Patterns of Enrollment, Utilization and Expenditures**

Project No.:	500-96-0026/04
Period:	September 1996-April 1998
Funding:	$123,590
Award:	Task Order
Principal Investigator:	George Kowalczyk
Awardee:	Jing Xing Health and Safety Resources, Inc. 7008-K Little River Turnpike Annandale, VA 22003
HCFA Project Officer:	M. Beth Benedict, Dr.P.H. Office of Strategic Planning

Description: The contractor will provide a range of programming, analytical, and statistical application skills needed to perform a wide range of tasks needed to support the research activities. This task order is to further HCFA's understanding of the patterns of enrollment, utilization and expenditures among Medicaid beneficiaries using Statistical Medicaid Research Files for 1992.

Status: Numerator and denominator files are being completed.

97-001 **Mortality: Medicaid and State Rates Using Death Certificate Data**

Project No.:	500-96-0516/04
Period:	January 1997-July 1998
Funding:	$35,841
Award:	Task Order
Principal Investigator:	Celia H. Dahlman
Awardee:	CHD Research Associates, Inc. 5515 Twin Knolls Road, No. 322 Columbia, MD 21045
HCFA Project Officer:	M. Beth Benedict, Dr.P.H. Office of Strategic Planning

Description: In a previous project, 1987-1988 Medicaid mortality rates for California, Georgia and Michigan were compared for all other State-level deaths. This task will analyze these data using additional variables. Analysis of the 1991 mortality data will be conducted and compared to the earlier results.

Status: The 1987-1988 analyses are complete and the 1991 data are being analyzed.

96-052 **Medicaid Early and Periodic Screening and Development Testing**

Project No.:	500-96-0026/02
Period:	September 1996-January 1998
Funding:	$95,805
Award:	Task Order
Principal Investigator:	George Kowalczyk
Awardee:	Jing Xing Health and Safety Resources, Inc. 7008-K Little River Turnpike Annandale, VA 22003
HCFA Project Officer:	Rosemarie Hakim, Ph.D. Office of Strategic Planning

Description: The contractor provided a range of programming, analytical, and statistical application skills needed to perform a wide range of tasks needed to support intramural research activities. This task order studied the utilization and expenditure patterns of children who received early and periodic screening diagnosis and treatment, and examined health outcomes of children with regard to use of early and periodic screening and development testing and follow-up services.

Status: The task order is completed.

96-011 **Comparison of Pharmaceutical Quality of Care for Pediatric Asthma Across Medicaid Populations**

Project No.:	500-96-0013/02
Period:	August 1996-July 1998
Funding:	$300,298
Award:	Task Order
Principal Investigator:	Janet Bronstein, Ph.D.
Awardee:	University of Alabama at Birmingham

	1825 University Blvd., MJH B23 Birmingham, AL 35294-2010
HCFA Project Officer:	M. Beth Benedict, Dr.P.H. Office of Strategic Planning

Description: This project will examine quality of care in the provision of health services to treat asthma in Medicaid children in two States: Alabama and Michigan. It will assess the extent of prescribing problems for pediatric asthma in these Medicaid programs. The investigators will test the validity of claims data to assess a sample of physician prescribing problems using medical records and Medicaid claims. The potential impact of a retrospective drug utilization review system will be simulated.

Status: Analyses are being conducted and medical records are being collected.

PREGNANT SUBSTANCE ABUSERS DEMONSTRATIONS

Description: Five States received multi-year awards for the purpose of implementing a demonstration projects to increase the number of Medicaid-eligible pregnant substance abusers who received coordinated perinatal care services, substance abuse treatment, and other relevant direct services for improving the health status of both mothers and their infants. Specifically, these project sites were to improve outreach and assessment; expand, integrate, and coordinate program services; and improve client case management. HCFA also awarded a contract to conduct an independent evaluation of the demonstration. The evaluation assessed the effects of services on the health of drug-addicted pregnant women, any prevention or reduction of short-term impairments to their infants, and the impact on birth outcomes. It also compared the cost of substance abuse treatment in residential facilities versus ambulatory care facilities. The demonstration sites and evaluation contractor are identified below.

91-085 Coordinating Care for Pregnant Substance Abusers Demonstration: South Carolina

Project No.:	11-C-06112/5
Period:	September 1991-December 1997
Funding:	$1,441,000
Award:	Cooperative Agreement
Principal Investigator:	Gwen Power
Awardee:	State of South Carolina P.O. Box 8206 Columbia, SC 29202-8206
HCFA Project Officer:	Lori Teichman, Ph.D. Center for Medicaid and State Operations

Description: The South Carolina "Transitions" project was implemented in the Edisto Health District, encompassing Calhoun, Orangeburg, and Bamberg Counties. The site is a poor area both urban and rural, where 58 percent of the population is African American, and 60 percent of the women are Medicaid-eligible. The State Medicaid agency's High Risk Channeling Project (HRCP) Freedom of Choice (FOC) Waiver is the point of entry into "Transitions." The demonstration project is used to supplement services through a family-centered solution process for clients. The Department of Alcohol and Other Drug Abuse Services coordinates with the Department of Health in providing a program centered on the three components of social work outreach services, perinatal/clinical substance abuse, services, and program evaluation.

Status: The project received waiver approvals for a 3-year period (July 1993, through June 1996). The final period of funding for the demonstration was October 1995 through December 1996. The project continued with a no-cost extension from January 1997 through July 1997 for the data needs of the evaluation contractor. The project continued to provide services to the enrolled high-risk clients in the phase-down period of the demonstration. A Final Report is due in December 1997.

91-086 Coordinating Care for Pregnant Substance Abusers Demonstration: New York

Project No.:	11-C-06115/5
Start Date:	September 1991-July 1997
Funding:	$1,700,000
Award:	Cooperative Agreement
Principal Investigator::	Thomas Fanning, Ph.D.
Awardee:	New York State Department of Health Corning Tower Bldg., Empire State Plaza Albany, NY 12237
HCFA Project	Bonnie M. Edington

Officer:	Office of Clinical Standards and Quality

Description: The New York project had six sites, three in New York City and three in upstate New York. The project had waivers permitting Medicaid to cover: residential treatment in institutions for mental disease (IMDs); and support services provided by medically supervised outpatient programs, including child care, vocational and adult educational activities, life skills/self-esteem building, and health education. A total of 509 women were identified as pregnant substance abusers; 270 were enrolled in ambulatory treatment programs and 137 were enrolled in residential programs.

Status: The demonstration has concluded and was evaluated by an independent evaluator. At the time of the evaluation, complete data was available for only 274 clients served by the demonstration's New York sites. Findings were that only 20 percent of the pregnant substance abusers in the demonstration areas were enrolled in the demonstration. However, compared to other pregnant substance abusers in the area, demonstration clients received an intense level of services, and had significantly lower rates of low birthweight, with reduced prenatal/delivery expenditures that offset the higher costs of treatment.

91-087 Coordinating Care for Pregnant Substance Abusers Demonstration: Massachusetts

Project No.:	11-C-06111/5
Period:	September 1991-December 1997
Funding:	$1,125,000
Award:	Cooperative Agreement
Principal Investigator::	Bruce Bullen and Milton Argenou, Ph.D.
Awardee:	State of Massachusetts Department of Public Welfare 600 Washington Street, 5th Floor Boston, MA 02111
HCFA Project Officer:	Lori Teichman, Ph.D Center for Medicaid and State Operations

Description: The MOTHERS (Medicaid Opportunities To Help Enter Recovery Services) project represented a program evaluation of the recruitment, enrollment, and treatment of pregnant women using illicit drugs in the greater Boston and Holyoke areas of the State. The site outcomes are to include a study of the costs and benefits associated with long-term treatment strategies, including residential, outpatient, and formal care following detoxification in 1 of 11 freestanding detoxification centers. Comparison between women who enter residential and outpatient treatment facilities will permit assessments of the relative impacts of these different modes of treatment.

Status: The project received waiver approval for a 3-year period (July 1, 1993, through June 30, 1996). The final period of funding for the demonstration was for October 1995 through December 1996. The project continued with a no-cost extension from January 1997 through July 1997 for the data needs of the evaluation contractor. The recruitment of women into the program ended December 31, 1995; a total of 663 women were serviced in the demonstration project. A draft final report was received in November of 1997 and the final report was received in December 1997.

91-096 Coordinating Care for Pregnant Substance Abusers Demonstration: Washington

Project No.:	11-C-06108/5
Period:	September 1991-July 1997
Funding:	$1,125,000
Award:	Cooperative Agreement
Principal Investigator::	Kathy Apodaka
Awardee:	Washington State Department of Social and Health Services Office of First Steps, MS OB-45A Olympia, WA 98504
HCFA Project Officer:	Bonnie M. Edington Office of Clinical Standards and Quality

Description: The Yakima First Steps Mobilization Project for Substance Abusing Pregnant Women: First Steps Plus was conducted in Yakima County, a predominantly rural area, and provided a continuum of care for low-income, pregnant substance abusers. Medicaid maternity care services provided through Washington's First Steps program were combined or coordinated with chemical addiction treatment and social services. Project services were provided throughout pregnancy and delivery, and for up to 1 year after delivery. The project expanded the range of Medicaid

services and increased coordination of the service-delivery community through communication, collaboration, and training. Additional Medicaid services provided through waivers included the following:

- Expanded outreach activities, including a mobile substance abuse assessment worker, and a screening form to assist prenatal care providers in identifying substance abusers.
- Expanded case management to provide more intensive involvement with project participants, and an increased payment rate for case management agencies.
- Residential treatment in Institutions for Mental Disease (IMDs) with specialized medical stabilization, detoxification, and treatment slots.
- Child care during substance abuse treatment.

Status: The project began providing services in July 1993. Over 9,000 pregnant women were screened and services were provided to 425 clients, 53 percent of the women identified as pregnant substance abusers. Findings were that the demonstration reached a relatively high proportion of pregnant substance abusers through innovative screening methods but did not significantly improve rates of prenatal care, substance abuse treatment, or infant birthweight, or reduce overall program expenditures. Medicaid expenditures were higher for demonstration clients in general, and there was no significant difference in birth outcomes between these clients and other pregnant substance abusers in the demonstration area. However, the subset of demonstration clients who remained in treatment longer had babies with significantly higher birthweight.

91-088 Coordinating Care for Pregnant Substance Abusers Demonstration: Maryland

Project No.:	11-C-06103/5
Period:	September 1991-December 1997
Funding:	$1,300,000
Award:	Cooperative Agreement
Principal Investigator:	Ann Kerns
Awardee:	State of Maryland 201 West Preston Street, Room 225 Baltimore, MD 21201
HCFA Project Officer:	Lori Teichman, Ph.D. Center for Beneficiary Services

Description: The project participants in the Maryland program have received targeted case management under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, which permits targeted case management to Medicaid recipients. This initiative is designed to fill a critical gap in improving birth outcomes for Medicaid enrollees: even when pregnant substance abusers are identified and services are available, there is a high risk that these women will not use appropriate services. This demonstration was designed to test whether the combination of case management in conjunction with support groups and comprehensive prenatal and drug treatment services is a more cost-effective outreach strategy than support groups alone. Outreach services for this project are carried out under the auspices of the Johns Hopkins Hospital (JHH) Comprehensive Women's Center (CWC), in conjunction with the JHH Prenatal Care Clinic. The CWC is a well-established drug treatment program, developed to provide specialized substance abuse services for women of childbearing age. The JHH is one of the largest providers of prenatal care to Medicaid women in Maryland.

Status: As of June 30, 1996, 154 women were participating in the randomized clinical intervention (52 in the clinical services group only, 43 in the clinical services and support group only, and 59 in the clinical services and support group with the individualized case management component). The final period of funding for the demonstration was for October 1995 through December 1996. The eligible study participants continued to receive services through December 31, 1996. The project continued with a no-cost extension from January 1997 through July 1997 for the data needs of the evaluation contractor, and will provide a phase-down period for the recently serviced client groups. A draft Final Report was received in July 1997 and a Financial report is to be received in December 1997.

92-069 Evaluation of the Demonstration for Improving Access to Care for Pregnant Substance Abusers

Project No.:	500-92-0049
Period:	September 1992-December 1997
Funding:	$2,131,844
Award:	Contract
Principal Investigator::	Embry Howell, Ph.D.

Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Suzanne Rotwein, Ph.D. Center for Beneficiary Services

Description: This project conducted an evaluation of the demonstration to improve access to Medicaid care for pregnant substance abusers. The demonstration was being implemented in Maryland, Massachusetts, New York, South Carolina, and Washington. The purposes of these projects were to improve outreach and assessment; expand, integrate, and coordinate program services; and improve client case management. The objective of the evaluation was to assess the effectiveness of interventions that are included in the demonstration projects. The evaluator assessed the effects of services on the health of drug-addicted pregnant women, any prevention or reduction of short-term impairments to their infants, and the impact on birth outcomes. The evaluation also will compare the cost of substance abuse treatment in residential facilities versus ambulatory care facilities.

Status: The evaluator found almost no significant differences in trends in the outcomes in the demonstration areas compared to trends in other similar areas where the demonstrations were not operating. The number of pregnant substance abusers enrolled in the demonstrations were low relative to all possible pregnant substance abusers in the area since women were reluctant to be identified. Some of the reasons given were social stigma, a desire to continue to use drugs, fear of prosecution and fear of losing their children. Positive findings included higher enrollment rates in States which implemented broad-based outreach efforts. Higher levels of, and greater retention in, substance abuse treatment was related to higher birth weight infants. The awardee is preparing a final report.

96-004 **Demonstration Project for Family Planning and Preventive Reproductive Services, State of Maryland**

Project No.:	11-W-00043/3
Period:	October 1994-January 2001
Award:	Waiver-only Project
Principal Investigator:	Susan Tucker
Awardee:	Maryland Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201
HCFA Project Officer:	Gloria J. Smiddy Center for Medicaid and State Operations

Description: Under this demonstration project, the State of Maryland proposes to extend Medicaid eligibility for family planning services to women who are Medicaid-eligible because of their pregnancy. These women will remain Medicaid-eligible 60-days postpartum (i.e., for those women who fall in the Pregnant Women and Children eligibility category). The State intends to demonstrate that covering family planning and preventive reproductive services for these women will reduce Medicaid payments by reducing their number of unintended births and by improving their health status through preventive care. The demonstration waivers run through January 30, 2000, with the last year of the project devoted to evaluation activities.

Status: The Department of Health and Mental Hygiene staff has:

- Developed a medical assistance recipient master file.
- Updated the automated eligibility verification system to include information on project participants' eligibility.
- Developed a list of services to be reimbursed under the program.
- Provided project recipients with identification cards.

The State of Maryland is in the process of moving to Year 4 of this 5-year demonstration project.

92-029 **Program of Preconceptional Intervention for Women at Risk for Low Birth Weight Infants: State of Florida**

Project No.:	11-C-90154/4
Period:	February 1992-May 1998
Funding:	$917,324
Award:	Cooperative Agreement
Principal Investigator:	Gary Crayton
Awardee:	Florida Agency for Health Care Administration P.O. Box 13000

	Tallahassee, FL 32317-3000
HCFA Project Officer:	Alisa Adamo Center for Medicaid and State Operations

Description: This demonstration project provides interconceptional services to women who have had a Medicaid-covered pregnancy and who meet at least one of the following criteria:

- Delivery of a low birth weight (LBW) baby;
- Absence of prenatal care; and/or
- Age is 15 years old or younger at the time of delivery.

The objectives of the program are to prevent subsequent pregnancies for at least 2 years, and to improve the health status of the women through behavioral changes. The project is implemented by the University of Florida (UF), and the Department of Biostatistics. The eligible women who give birth to LBW infants are identified subsequent to the deliveries at the UF Shands Hospital, the medical site where the majority of indigent women in the 10-county demonstration area are scheduled for Medicaid-covered deliveries. The women who volunteer to participate are randomly assigned to either the service or control groups. The project's services are provided in the clients' homes on a one-to-one basis, by paraprofessionals who are known as "Resource Mothers."

Status: A total of 599 women participated in the study (326 in the service group and 273 in the control group). Approximately half of the women in the service group completed the program.

96-082 **Improving Outcomes for Low-Income Pregnant Women: Effects of Medicaid Eligibility and Alternative Delivery Systems**

Project No.:	500-96-0017/02
Period:	June 1996-May 1998
Funding:	$179,121
Award:	Task Order
Principal Investigator:	Stephen H. Long
Awardee:	The Rand Corporation 1700 Main Street Santa Monica, CA 90407-2138
HCFA Project Officer:	Penelope L. Pine Office of Strategic Planning

Description: The project will extend the database and analysis from a previous HCFA study of the 1989 Florida Medicaid eligibility expansions for pregnant women. This observational study will look at the variations in Medicaid eligibility and the role of different delivery systems in providing prenatal care to Medicaid enrollees in Florida over the years 1988-1994.

The study will:

- Estimate variation in birth outcomes among Medicaid beneficiaries using different delivery systems.
- Estimate the effects of Medicaid eligibility and use of alternative delivery systems on outcomes for subgroups of low-income women.
- Estimate whether providing care directly through the public health system substitutes for providing public insurance to improve access to the private delivery system.

Status: The first year of the project was occupied with data collection activities and site visits to the State to learn about Medicaid program changes, managed care, and other maternal and child health initiatives.

97-222 **Analysis of Early Childhood Preventive Health Care**

Project No.:	HCFA-IA-97-67
Period:	May 1997-September 1997
Funding:	$50,000
Award:	Intra-agency Agreement
Principal Investigator:	Don Reed
Awardee:	National Center for Health Statistics Bethesda, MD
HCFA Project Officer:	Rosemarie Hakim, Ph.D. Office of Strategic Planning

Description: This project was a longitudinal analysis of preventive care in young children using the National Maternal and Infant Health Survey data. The analysis was performed by Kevric, Inc., under a contract with the National Center for Health Statistics.

Status: This work has been completed.

92-056 Medicaid Program Research to Study Medicaid Policy Alternatives for the State of New York

Project No.:	500-92-0059
Period:	September 1992-March 1997
Funding:	$194,090
Award:	Contract
Principal Investigator:	Thomas Fanning, Ph.D.
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, NY 12243-0001
HCFA Project Officer:	Penelope L. Pine Office of Strategic Planning

Description: The purposes of this contract are to provide HCFA with greater capability to conduct Medicaid program research and to study Medicaid policy alternatives of the State of New York. Primary goals are the following:

- Obtain person-level Medicaid Management Information Systems data from the State.
- Produce research data sets for analysis of Medicaid costs and service utilization.
- Conduct policy-oriented research studies derived from knowledge of the data, program characteristics, and policy issues that exist in the New York Department of Social Services.
- Provide support to HCFA staff who will conduct policy-related studies using New York Medicaid research data sets.

Status: Data files for the years 1990 and 1991 on Medicaid utilization have been completed and delivered to HCFA. We are waiting for the final report to be completed.

94-077 Changes in Population Characteristics and Medicaid Utilization/Expenditures among Children and Adolescent Supplemental Security Income Recipients

Project No.:	18-C-90455/1
Period:	September 1994-September 1997
Funding:	$642,035
Award:	Cooperative Agreement
Principal Investigator:	James Perrin, M.D.
Awardee:	Massachusetts General Hospital Children's Service Fruit Street, WACC715 Boston, MA 02114
HCFA Project Officer:	Paul Eggers, Ph.D. Office of Strategic Planning

Description: The Supplemental Security Income (SSI) program for children and adolescents has expanded in the past 5 years as a result of new Social Security Administration (SSA) guidelines for determining disability caused by mental impairments, new guidelines for determining childhood disability in general, and major outreach efforts by SSA to identify children with disabilities. The project has four main objectives:

- Determine the current clinical characteristics of child and adolescent SSI recipients and the changes in these characteristics during the period of program expansion that began in the late 1980s.
- Determine patterns of Medicaid utilization and expenditures among important clinical subgroups and examine changes in these patterns during the period of program expansion.
- Examine the utilization trajectories and clinical characteristics of certain SSI recipient groups over time, including recipients with high-cost physical conditions such as cystic fibrosis, congenital heart disease, and spina bifida, and high-prevalence, low-cost conditions such as attention deficit disorder, hyperactivity, and learning disabilities.
- Determine the degree to which new recipients reflect shifting among Medicaid eligibility categories and the coverage and use of other insurance after getting SSI.

Status: Analyses were underway and one paper has been submitted for publication--"State Variations in Supplemental Security Income Enrollment for Children and Adults." The multiple regression analyses assessed the effect of poverty, program generosity and child health indicators on State variations in child and adolescent enrollment in SSI. The mean percentage of children grew from 0.36 percent in 1989 to 0.75 percent in 1992. Poverty rates accounted for 28 percent of State variance in 1989 but 53 percent in 1992. No other indicator accounted for much variance. The paper, "Supplemental Security Income for Children: Are New Enrollees Also New to Medicaid or Upgrades from

A.F.D.C. Upgrades?" found that about half of the children newly receiving SSI benefits had previously received Aid to Families with Dependent Children benefits and thus experienced a major increase in monthly cash benefits. The other half of new SSI recipients were new to public insurance. Three other papers are underway: "Secular Trends in Conditions Among Children Receiving SSI Benefits," which found that the number of SSI children in institutions increased minimally (3 percent), despite an 83-percent increase in SSI enrollment. The number of children with leukemia enrolled in SSI increased 33 percent, while those with other physical conditions increased over 70 percent; the number of children with mental retardation increased 615. In contrast, the number of SSI children with asthma increased dramatically (185 percent), but at a rate similar to the 162-percent increase in asthma among the non-SSI Medicaid population. A four-fold increase in "Attention Deficit Hyperactivity Disorder" among SSI enrollees is comparable to the four-fold increase in the condition among the non-SSI Medicaid enrolled children. "The Supplemental Security Income Children's Disability Program: Impact of Program Growth on Population with High Expenditures." This preliminary analysis on only Georgia data found that the number of children with costs over $25,000 decreased very slightly from 4.3 percent of the SSI population in 1989 to 4.1 percent in 1992.

97-013 **Childhood Injuries in the Medicaid Population**

Project No.:	500-96-0026/06
Period:	March 1997-March 1998
Funding:	$79,730
Award:	Task Order
Principal Investigator:	George Kowalczyk
Awardee:	Jing Xing Health and Safety Resources, Inc. 7008-K Little River Turnpike Annandale, VA 22003
HCFA Project Officer:	David K. Baugh Office of Strategic Planning

Description: This task order provides support for an intramural study of the same name. Injuries are a significant cause of mortality and morbidity in the U.S. population, particularly among persons under age 21 and among the vulnerable populations served by Medicaid. Little is known about the incidence, prevalence and program expenditures for injuries under Medicaid. This study will provide baseline data on utilization and payments for injuries by Medicaid in selected States. Since many injuries are preventable, this effort will lead to other studies that should assist us in understanding the extent and types of injuries experienced by Medicaid enrollees and provide input to a process of preventing injuries and containing cost for injuries within Medicaid.

Status: The contractor is testing software to extract injury services from both inpatient hospital and outpatient State Medicaid Research Files. Initial testing of the tabulation specifications is also under way.

97-217 **Service Utilization Patterns for Preventive Care for Undocumented Alien Children under California's Medi-Cal Program**

Project No.:	HCFA-97-0429
Period:	September 1997-January 1998
Funding:	$20,979
Award:	Purchase Order
Principal Investigator:	Michael J. Brown
Awardee:	MedStat Group, The 5425 Hollister Avenue Santa Barbara, CA 93111
HCFA Project Officer:	Paul W. Eggers, Ph.D. Office of Strategic Planning

Description: The project will provide an analysis of service utilization and expenditure patterns for preventive and illness-related care for undocumented alien children under California's Medi-Cal program. The contractor will initially develop a database of undocumented alien children covered by the California Medicaid program (Medi-Cal). They will do this by using State-specific eligibility codes for the years 1989-1992. They will then provide descriptive analyses of enrollees, utilization and payments for this group, the proportions of total Medicaid child enrollees, utilization and payments that these children represent and a descriptive analysis of the classification of services, including emergency, preventive and non-emergency, along with the sites of such services. They will also examine the magnitude of expenditures for this group of undocumented alien children and the numbers of such, the average expenditures per child and per person month of eligibility.

Status: The analytic plan has been submitted and data development and initial analyses are underway.

88-016 Medical Assistance Facility Demonstration Project

Project No.:	95-C-99292/8
Period:	June 1988-September 1998
Funding:	$140,939
Award:	Cooperative Agreement
Principal Investigator:	Keith McCarty
Awardee:	Montana Hospital Research P.O. Box 5119 Helena, MT 59604
HCFA Project Officer:	Siddhartha Mazumdar, Ph.D. Center for Health Plans and Providers
Mandates:	Omnibus Budget Reconciliation Act of 1990; Omnibus Budget Reconciliation Act of 1993; Balanced Budget Act of 1997.

Description: The Montana Hospital Research and Education Foundation (MHREF) is conducting a demonstration of the utility and desirability of medical assistance facilities (MAFs), limited-service hospital models located in remote, rural frontier areas. The MAF is a new category of licensure in Montana for health care facilities providing emergency, outpatient, and low-intensity acute-care services to short-term inpatients. MAFs are intended to maintain accessibility to basic acute and emergency-care services and provide limited inpatient care for no longer than 96 hours. These facilities are located in counties with fewer than six residents per square mile or in areas more than 35 miles from the nearest hospital. MAFs maintain agreements with larger full-service hospitals and other providers to ensure the availability of a full network of services. In enacting section 4008(I)(1) of the Omnibus Budget Reconciliation Act of 1990, Congress provided the authority to implement the demonstration. Section 13507 of the Omnibus Budget Reconciliation Act of 1993 amended this section of the law and extended the demonstration through July 1997. This project consists of two phases.

Status: The MAF demonstration is the first time that limited-service hospitals have received HCFA certification to be reimbursed for the provision of inpatient services to Medicare beneficiaries. The project has served as a prototype in the development of the Essential Access Community Hospital program. HCFA and MHREF have worked to develop the MAF concept by defining service, staffing, and equipment capabilities at each of the demonstration sites. In addition, use and cost projections have been prepared to estimate the financial impact of the project on the facilities and on the Medicare program. HCFA and MHREF have developed conditions of participation and certification requirements, quality assurance and use review procedures, and payment systems for MAFs. MAFs are reimbursed for the provision of all services on a reasonable-cost basis by the Medicare and Medicaid programs (Blue Cross and Blue Shield of Montana also participates in the demonstration by reimbursing MAFs on a reasonable-cost basis.) Ten MAFs are operating currently in Montana. The Balanced Budget Act of 1997 created a new program called the "Critical Access Hospital Program," which is intended to subsume these projects. As 1997 finished, this process was underway.

95-058 Evaluation of Rural Health Clinics

Project No.:	500-92-0047/03
Period:	September 1995-November 1997
Funding:	$316,051
Award:	Delivery Order
Principal Investigator:	Valerie Cheh, Ph.D.
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW., Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	Siddhartha Mazumdar, Ph.D. Center for Health Plans and Providers

Description: The Rural Health Clinic Services Act of 1977 authorized a new type of provider for certification and licensure. A rural health clinic (RHC) must be located in a rural health professional shortage area, medically underserved area, or Governor-designated shortage area, and it must make use of mid-level practitioners. The legislation provides for cost-based reimbursement for the clinics for Medicare and Medicaid. After a slow start in certifying clinics in the first years of the program, there has been rapid growth in the numbers of these clinics in the past few years. According to a count by HCFA, there were 3,067 RHCs listed nationwide in September 1996, compared to 1,157 certified clinics in August 1993.

This contract evaluated the program, and focused on several broad issue areas that have implications for rural health policy at the Federal and State levels. These overall issue areas were:

- What are the reasons for the growth in the numbers of the RHCs?
- What has been the impact on access to health care for rural populations as a result of the growth in these clinics, especially the Medicare, Medicaid, and otherwise underserved populations?
- What have been the costs to the Federal Government and the States for the program?

Other broad questions pertinent to the entire spectrum of rural health policy were also addressed, such as whether these clinics increased the supply of physicians in rural areas, what implications the growth in clinics had for Federal policy for rural hospitals and other providers, and whether these clinics should be protected in the development of State managed care plans.

Status: The report has been submitted.

ESSENTIAL ACCESS COMMUNITY HOSPITAL/RURAL PRIMARY CARE HOSPITAL PROGRAM

Mandate: Section 1820 of the Social Security Act

Description: The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program was designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, establishment of rural health networks, and creation of a limited-service alternative for communities that can no longer support a full-service hospital. The EACH/RPCH program consists of:

- A permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services.
- Grants to States and hospitals to assist in the development and implementation of the program.

EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, HCFA selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. HCFA has awarded a total of $23.7 million in grant funds to these States and 96 hospitals in these States for program planning and participation.

91-091 **Essential Access Community Hospital/Rural Primary Care Hospital Program: Kansas**

Project No.:	60-P-07017/7
Period:	September 1991-September 1998
Funding:	$5,799,223
Award:	Grant
Principal Investigator:	Thomas R. Sipe
Awardee:	Kansas Department of Health and Environment 900 SW. Jackson Topeka, KS 66612-1290
HCFA Project Officer:	William Damrosch Center for Health Plans and Providers

Status: Since 1991, the Kansas Bureau of Local and Rural Health Systems has received $979,702 in grant funding for program planning, development, and implementation. Grants totaling $4,819,521 have also been awarded to 29 Kansas hospitals in 9 rural health networks. As of September 1996, 11 RPCHs in Kansas have been certified to participate in the Medicare program. The EACH/RPCH program has gone national as part of the Medicare Rural Hospital flexibility Program. Therefore, these programs are no longer demonstrations. The projects in this State are completing their current grant periods.

91-093 **Essential Access Community Hospital/Rural Primary Care Hospital Program: North Carolina**

Project No.:	60-P-07012/4
Period:	September 1991-December 1997
Funding:	$4,135,369
Award:	Grant

Principal Investigator:	Nan Rideout
Awardee:	North Carolina Department of Human Resources 311 Ashe Avenue Raleigh, NC 27606
HCFA Project Officer:	William Damrosch Center for Health Plans and Providers

Status: Since 1991, the North Carolina Office of Rural Health and Resource Development has received $1,379,369 in grant funding for program planning, development, and implementation. Grants totaling $2,756,000 have also been awarded to 14 North Carolina hospitals in 7 rural health networks. As of September 1996, three RPCHs have been certified to participate in the Medicare program in North Carolina. The EACH/RPCH program has gone national as part of the Medicare Rural Hospital Flexibility Program. Therefore, these programs are no longer demonstrations. The projects in this State are completing their current grant periods.

91-092 **Essential Access Community Hospital/Rural Primary Care Hospital Program: New York**

Project No.:	60-P-07015/2
Period:	September 1991-December 1997
Funding:	$2,272,432
Award:	Grant
Principal Investigator:	Walt Gregg
Awardee:	New York State Department of Health Corning Tower, Room 1656 Albany, NY 12237
HCFA Project Officer:	William Damrosch Center for Health Plans and Providers

Status: Since 1991, the New York State Office of Rural Health has received $1,225,432 in grant funding for program planning, development, and implementation. Grants totaling $1,047,002 have also been awarded to six New York hospitals in three rural health networks. As of September 1996, two RPCHs had been certified to participate in the Medicare program in New York. The EACH/RPCH program has gone national as part of the Medicare Rural Hospital flexibility Program. Therefore, these programs are no longer demonstrations. The projects in this State are completing their current grant periods.

91-095 **Essential Access Community Hospital/Rural Primary Care Hospital Program: West Virginia**

Project No.:	60-P-07008/3
Period:	September 1991-December 1997
Funding:	$2,735,096
Award:	Grant
Principal Investigator:	Sandra Pope
Awardee:	West Virginia Department of Health and Human Resources 1411 Virginia Street, East Charleston, WV 25301
HCFA Project Officer:	William Damrosch Center for Health Plans and Providers

Status: The State of West Virginia is one of seven States participating in the EACH/RPCH program. Since 1991, the West Virginia Office of Community and Rural Health Services has received $1,058,330 in grant funding for program planning, development, and implementation. Grants totaling $1,676,766 have also been awarded to 12 West Virginia hospitals in 6 rural health networks. As of September 1996, six RPCHs have been certified to participate in the Medicare program in West Virginia. The EACH/RPCH program has gone national as part of the Medicare Rural Hospital Flexibility Program. Therefore, these programs are no longer demonstrations. The projects in this State are completing their current grant periods.

91-089 **Essential Access Community Hospital/Rural Primary Care Hospital Program: California**

Project No.:	60-P-07011/9
Period:	September 1991-September 1997
Funding:	$1,798,602
Award:	Grant
Principal Investigator:	Ernesto Iglesias
Awardee:	Office of Statewide Health Planning and Development 1600 9th Street, Room 440 Sacramento, CA 95814
HCFA Project Officer:	William Damrosch Center for Health Plans and Providers

Status: The State of California is one of seven States participating in the EACH/RPCH program. Since 1991, the California Office of Statewide Health Planning and

Development has received $714,102 in grant funding for program planning, development, and implementation. Grants totaling $1,084,500 have also been awarded to seven California hospitals in three rural health networks. The EACH/RPCH program has gone national as part of the Medicare Rural Hospital Flexibility Program. Therefore, these programs are no longer demonstrations. The projects in this state are completing their current grant periods.

91-090 Essential Access Community Hospital/Rural Primary Care Hospital Program: Colorado

Project No.:	60-P-07006/8
Period:	September 1991-December 1997
Funding:	$4,523,039
Award:	Grant
Principal Investigator:	Louise Singleton
Awardee:	Colorado Department of Public Health and Environment 4300 Cherry Creek Drive, South Denver, CO 80222-1530
HCFA Project Officer:	William Damrosch Center for Health Plans and Providers

Status: The State of Colorado is one of seven States participating in the EACH/RPCH program. Since 1991, the Colorado Office of Rural and Primary Health Policy and Planning has received $1,459,904 in grant funding for program planning, development, and implementation. Grants totaling $3,074,135 have also been awarded to 16 Colorado hospitals in 9 rural health networks. As of September 1996, two RPCHs in two rural health networks in Colorado have been certified to participate in the Medicare program. The EACH/RPCH program has gone national as part of the Medicare Rural Hospital Flexibility Program. Therefore, these programs are no longer demonstrations. The projects in this State are completing their current grant periods.

91-094 Essential Access Community Hospital/Rural Primary Care Hospital Program: South Dakota

Project No.:	60-P-07023/8
Period:	September 1991-December 1997
Funding:	$2,414,475
Award:	Grant
Principal Investigator:	Doug Knutson
Awardee:	South Dakota Department of Health 445 East Capitol Avenue Pierre, SD 57501-3185
HCFA Project Officer:	William Damrosch Center for Health Plans and Providers

Status: The State of South Dakota is one of seven States participating in the EACH/RPCH program. Since 1991, the South Dakota Office of Rural Health has received $741,782 in grant funding for program planning, development, and implementation. Grants totaling $1,672,693 have also been awarded to 12 South Dakota hospitals in 6 rural health networks. As of September 1996, six RPCHs have been certified to participate in the Medicare program in South Dakota (one of these RPCHs has closed). The EACH/RPCH program has gone national as part of the Medicare Rural Hospital flexibility Program. Therefore, these programs are no longer demonstrations. The projects in this State are completing their current grant periods.

94-063 Effects of Telemedicine on Accessibility, Quality, and Cost of Health Care

Project No.:	18-P-90332/5
Period:	July 1994-March 1998
Funding:	$644,086
Award:	Grant
Principal Investigator:	F. W. Womack
Awardee:	University of Michigan 3003 South State Street Ann Arbor, MI 48109-1274
HCFA Project Officer:	Joel W. Greer, Ph.D. Office of Strategic Planning

Description: This project evaluated the effect of telemedicine systems on accessibility, quality, and cost of health care. A detailed methodology for evaluating telemedicine was developed by a panel of experts and implemented in existing telemedicine programs at the Medical College of Georgia (MCG) Telemedicine Center and Mountaineer Doctor Television (MDTV) at the Health Sciences Center, West Virginia University (WVU). Included in the evaluation design was a quasi-experimental survey study of clients and providers in selected experimental and control communities and a case control study to compare the content, process, and outcomes of episodes of care with and without

telemedicine. The project plan had three goals:

- Development of a detailed methodology for a comprehensive evaluation of the effects of telemedicine on accessibility, utilization, quality, and cost of health care, using a panel of experts on quality, economics, clinical medicine, and technology.
- Implementation and testing of the evaluation design at the MCG Telemedicine Center.
- Extending the evaluation design to MDTV at WVU.

The general hypothesis guiding this research was that telemedicine will improve accessibility to health care, enhance the quality of care delivered, and contain costs.

Status: The final report is being prepared.

94-211 **Rural Telemedicine Demonstration**

Project No.:	95-P-90367
Period:	September 1994-September 1998
Funding:	$635,366
Award:	Grant
Principal Investigator:	Susan Gustke
Awardee:	East Carolina University School of Medicine Greenville, NC 27858
HCFA Project Officer:	William L. England, Ph.D., J.D. Office of Clinical Standards and Quality

Description: This project is collecting case studies and hard data describing the impact and quality of medical care in remote areas. Other items being studied include use rates and cost structure, types of services appropriate to telemedicine, diagnostic effectiveness, and payment methodology. This project is part of the Medicare telemedicine demonstration, which is testing a system for Medicare payment for telemedicine services involving five rural North Carolina hospitals: Bertie Memorial Hospital in Windsor; Chowan Hospital in Edenton; Pungo District Hospital in Belhaven; Roanoke-Chowan Hospital in Ahoskie; Martin General Hospital in Endfield; and a clinic, Goshen Medical Clinic, in Faison. All of these facilities are linked to the regional medical center and medical school affiliate, Pitt County Memorial Hospital, to deliver primary care services. The project has eight objectives:

- To evaluate the impact of telemedicine on access to care.
- To determine specialty services appropriate for rural telemedicine.
- To determine whether the type of health care provider presenting the patient to the consultant affects the quality and clinical value of the consultation.
- To evaluate the educational value of the telemedicine consultation.
- To develop a prototype for delivery of telemedicine services.
- To determine if the diagnostic effectiveness for dermatological examinations can be maintained via telecommunications.
- To evaluate the costs of providing telemedicine services (direct, indirect, and ancillary).
- To examine the impact of payment for telemedicine services on the actual consultation and on the broader health care delivery system.

Status: A waiver to permit provider payment under Medicare was approved for this project in October 1996. During the first 10 months under the waiver, the project reported 86 Medicare consults were conducted, although the Medicare claims system reported only 28 consults recorded and paid. The difference is being investigated. In total, the project reports 1,720 teleconsultations conducted since the project began several years ago, with the majority being in the prison system and most of the remainder being funded by the Federal Office of Rural Health Policy. Because the number of Medicare consults is so low, no analysis or results are yet available for that segment. As a result of delays in awarding the Medicare telemedicine waiver and the slow start-up under Medicare, this project was given a 1-year no-cost extension from its prior September 1997 termination date.

94-065 **Bundle Payment for Physician and Hospital Services Using Telemedicine Services**

Project No.:	95-C-90384/3
Period:	July 1994-July 1997
Funding:	$1,568,476
Award:	Grant
Principal Investigator:	Kevin Halbritten, M.D.
Awardee:	West Virginia University Research Corporation

	P.O. Box 6845 Morgantown, WV 26506-6845
HCFA Project Officer:	William L. England, Ph.D., J.D. Office of Clinical Standards and Quality

Description: This project is investigating whether changing the current Medicare payment policy for telemedicine enhances patients' access to care and improves the quality of care delivered in rural communities, while limiting the growth of health care spending. West Virginia University's Mountaineer Doctor Television (MDTV) program currently links seven rural spoke sites (Davis Memorial Hospital in Elkins, Grant Memorial Hospital in Petersburg, Boone Memorial Hospital in Madison, St. Joe's Hospital in Buckhannon, William Sharpe Hospital in Weston, Roane General Hospital in Spencer, and Braxton County Memorial Hospital in Gassaway) with two hub sites, the Robert C. Byrd West (Virginia University) Health Sciences Center in Morgantown and Charleston Area Medical Center in Charleston. While hospital and administrative expenses for telemedicine are covered by this grant, payment for actual delivery of medical care is done under a demonstration waiver of Medicare payment regulation. The major objective of this project is to develop a payment system for inpatient telemedicine consultations. Related objectives include development of a coding system for inpatient telemedicine consultations, increasing the number of inpatient telemedicine consultations, and reducing interhospital transfers by 50 percent. The effect of the payment system on the number and types of charges generated by Medicare patients at rural MDTV sites will be evaluated. The cost effectiveness and feasibility of telemedicine follow-up for patients returned from the referral center to the rural hospitals for the remainder of their hospitalization is also being evaluated.

Status: A waiver to permit provider payment under Medicare was approved for this project in October 1996. During the first 10 months under the waiver, the project reported 26 Medicare consults were conducted, although the Medicare claims system reported only 6 consults recorded and paid. The difference is being investigated. In total, the project reported 248 teleconsultations were conducted during the first 6 months of 1997, with the majority being in the prison system or other non-Medicare beneficiaries. Because the number of Medicare consults is so low, no analysis or results are yet available for that segment. As a result of delays in awarding the Medicare telemedicine waiver and the slow start-up under Medicare, this project was given a 1-year no-cost extension from its prior September 1997 termination date.

94-066 Midwest Rural Telemedicine Consortium: A Pilot Demonstration Project

Project No.:	95-P-90425/7
Period:	July 1994-January 1998
Funding:	$3,229,236
Award:	Grant
Principal Investigator:	Harrison Pratt, D.O.
Awardee:	Mercy Foundation Sixth and University Des Moines, IA 50314
HCFA Project Officer:	Lawrence E. Kucken Office of Clinical Standards and Quality

Description: This project is evaluating the medical effectiveness, patient and provider acceptance, and costs associated with telemedicine services, as well as their impact on access to care in rural areas. The demonstration involves 10 rural hospitals, 1 rural referral hospital, and 1 urban hospital. Planned services for the demonstration include interactive video consults for teleradiology, telepathology, and, where available, telesonography, electrocardiography, and fetal monitoring strips. Payment for related physician services is expected to be made under a waiver of Medicare payment regulations. The goal of the project is to evaluate whether specialty telemedicine services provided by hospital networks produce change with respect to medical effectiveness, patient and provider satisfaction, cost, and access. Hypotheses include telemedicine improving differential diagnoses and treatment, patients and providers being as satisfied with telemedicine as with on-site services, telemedicine services being less costly than on-site services, and telemedicine improving access to a wider range of health care services.

Status: This telemedicine network has been implemented. A Medicare waiver to permit payment to providers participating in the project was awarded in October of 1996. The preparation of the final report has begun.

95-023 **Maximizing the Effective Use of Telemedicine: A Study of the Effects, Cost Effectiveness, and Utilization Patterns of Consultation via Telemedicine**

Project No.:	18-C-90617/8-0
Period:	September 1995-September 1998
Funding:	$1,346,639
Award:	Cooperative Agreement
Principal Investigator:	Jim Grigsby, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Blvd., Suite 306 Denver, CO 80202
HCFA Project Officer:	Joel W. Greer, Ph.D. Office of Strategic Planning

Description: The objective of this project is to design and conduct a comprehensive evaluation of HCFA's telemedicine research and demonstration projects. The awardee, in consultation with the individual demonstration sites, has formulated a cross-cutting evaluation design, including data collection and analysis, to assess the effect of alternative payment options for the providers of telemedicine services, including fee-for-service and a "bundled payment" approach. The awardee will devise objective measures of the cost of telemedicine services in different clinical settings, both from the payer's and the provider's perspective; will examine provider and patient satisfaction; and will examine utilization measures such as physician visits, hospitalizations, complications or comorbidities, and the effect of telemedicine on practice patterns. HCFA expects to use information gained from this project to develop a cost-effective payment strategy for telemedicine services in Medicare.

Status: The evaluation design has been completed and the data collection instrument has been approved. Data collection began in September 1997.

94-212 **Rural Health Care Transition Grants in Fiscal Year 1993**

Project No.:	500-94-0011
Period:	March 1994-April 1997
Funding:	$1,121,413
Award:	Contract
Principal Investigator:	Don F. Lara
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543
HCFA Project Officer:	Siddhartha Mazumdar, Ph.D. Center for Health Plans and Providers

Description: These contracts individually focused on the monitoring and evaluation of the yearly grantee cohorts. With the exception of Connecticut, Delaware, Massachusetts, New Jersey, and Rhode Island, all States participated in the rural health transition program. In accordance with the change of the authorizing legislation, the evaluator produced annual reports on the grant program for submission to Congress. These reports present general status descriptions on the progress of the grantees, including what services were provided with grant funds. In addition, the reports focused on special topics pertaining to the grantee hospitals and rural health issues in general (e.g., how hospitals in low-income areas survive financially and the contribution of mid-level practitioners to small rural hospitals).

Status: The report was delivered.

94-121 **Rural Health Care Transition Grant Evaluation**

Project No.:	500-95-0032
Period:	September 1995-April 1998
Funding:	$308,353
Award:	Contract
Principal Investigator:	Craig Thornton, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Siddhartha Mazumdar, Ph.D. Center for Health Plans and Providers

Description: Mathematica Policy Research, Inc. (MPR) is performing post-award functions for fiscal years 1992, 1993, 1994, 1995, and 1996 Rural Health Care Transition grantees, which include the following:

- Monitoring grantees to determine how grant funds are being spent.
- Maintaining an ongoing profile of the grantees' progress in planning and/or implementing the components of their programs.
- Reporting to HCFA the results of the monitoring, the perceived needs of rural hospitals, and the

evaluation of the projects and of the impact and effectiveness of the program.

These contracts individually focus on the monitoring and evaluation of the yearly grantee cohorts. With the exception of Connecticut, Delaware, Massachusetts, New Jersey, and Rhode Island, all States participated in the rural health transition program. In accordance with the recent change of the authorizing legislation, MPR is currently producing annual reports on the grant program for submission to Congress. These reports present general status descriptions on the progress of the grantees, including what services they are providing with grant funds. In addition, the reports focus on special topics pertaining to the grantee hospitals and rural health issues in general (e.g., how hospitals in low-income areas survive financially and the contribution of mid-level practitioners to small rural hospitals).

Status: Consistent findings from the MPR evaluation include the following:

- Local access to specific services has increased inasmuch as grant funding has produced a variety of new services that patients are using; however, overall utilization and services have been unaffected by the grant program.
- Problems have persisted in recruiting and retaining physicians.
- The closure rate for grantee hospitals is equivalent to the closure rate for small rural hospitals nationwide; the grant program generally has failed to produce consolidation and conversion among hospitals.

Theme IV: Information to Improve Consumer Choice and Health Status

HCFA is committed to developing new ways to use its data to improve beneficiaries' knowledge and their ability to make more informed health care choices, both in the health plans they select and in the services they use. These information systems can be instrumental in meeting HCFA's goal of better understanding beneficiaries' health and information needs and of improving their health status. The development of information systems to support the consumer can also be applied to provide health plans and health care providers with more information on consumer preferences and needs. Expanded consumer information and education programs will improve beneficiaries' ability to choose between expanded managed care options in the future.

95-211 **Approaching Death: Decisionmaking and Appropriate Care**

Project No.:	500-95-0026
Period:	September 1995-September 1997
Funding:	$150,000
Award:	Contract
Principal Investigator:	David Westbrook
Awardee:	National Academy of Sciences 2101 Constitution Ave, NW. Washington, DC 20418
HCFA Project Officer:	Rosemarie Hakim, Ph.D. Office of Strategic Planning

Description: The project studied and developed recommendations to improve care for those approaching death. Project objectives were:

- To assess the state of knowledge about important aspects of care for patients with life-threatening medical problems.
- To evaluate methods for measuring outcomes, predicting survival and functional status, determining patient and family preferences, and assessing quality of care.
- To propose steps to improve care for those with terminal illnesses and to increase agreement on what constitutes appropriate care.

Key questions were:

- How prevalent is the problem of some confusion among patients and providers regarding patients' rights to refuse medical treatment?
- Is it possible to estimate the expenditures for treatments provided, which dying patients do not want?
- What types of educational programs for patients and providers would improve understanding of patients' rights to decline medical treatment?
- What types of initiatives might improve patients' development of advance directives?

Status: This work has been completed. The final report of this project is published as a book and is available from the National Academy Press: *Approaching Death: Improving Care at the End of Life*, Marilyn J. Field and Christine L. Cassel, editors, Division of Health Care Services, Institute of Medicine, National Academy Press, Washington D.C., 1997. ISBN 0-309-06372-8.

94-098 **Information Needs for Consumer Choice**

Project No.:	500-94-0048
Period:	September 1994-June 1998
Funding:	$714,719
Award:	Contract
Principal Investigator:	Barri Barrus, Ph.D.
Awardee:	Research Triangle Institute P.O. Box 12194 Research Triangle Park, NC 27709
HCFA Project Officer:	Maria Friedman, D.B.A. Center for Medicaid and State Operations

Description: This contract examined the types of information consumers find most useful in selecting health insurance plans, providers, and practitioners, and in making the chosen health care plan/system work best for them. The study determined how to present this type of information in a user-friendly way and developed and tested these consumer information approaches in given markets. The project addressed consumer information issues and needs in both the current health care system and in proposals for health care system reform, especially as they relate to three broad consumer groups:

Medicare beneficiaries, Medicaid beneficiaries, and the remaining U.S. population under 65 years of age. Contract tasks included conducting up to 24 focus groups, conducting 9 case studies of innovative consumer information projects, and developing and testing information materials in 2 different media for 6 subgroups of the Medicare and Medicaid populations.

Status: The focus groups and case studies have been completed. The results of the focus groups indicate that information needs varied across insurance groups. In general, Medicare beneficiaries were concerned with their access to current providers and the specialists of their choice, providers' communication skills, technical quality of care, and specific benefits relevant to their circumstances. Beneficiaries were aware of cost, but it was rarely a primary decision factor. Many of those approaching Medicare eligibility were uninformed about the basic structure of Medicare and supplemental coverage. Medicaid eligibles were most interested in access to after-hours care, provider choice, waiting time, and providers' communication and interpersonal skills. Participants assessed the usefulness of three kinds of information for plan choice: consumer ratings, quality-of-care measures, and cost comparisons. Most responded favorably to samples of consumer ratings of plan performance. Differences in familiarity with surveys was apparent, with some participants requiring explanation of basic concepts of an independent survey, while others raised fairly sophisticated concerns regarding survey design and administration. Participant reactions to quality-of-care measures were more cautious. Many saw preventive care utilization as indicative of consumers' responsible actions rather than plan quality. Media preferences varied by insurance groups. Medicare beneficiaries consistently preferred a combination of individual or group presentations with printed reference material. Medicaid eligibles wanted group counseling sessions, similar to those they currently receive, but with the addition of detailed information on available plans. All participants said they preferred to receive information from unbiased, consumer-oriented sources. The case study component of this project served an important purpose, which was to learn about and from organizations across the country that were developing information to assist consumers in choosing a health plan and using the health care system. A total of 24 in-person interviews were conducted with a variety of organizations active in the consumer information field. Through the case studies, we identified a list of candidate performance measures, or quality indicators, for inclusion in our prototype materials that will be developed and tested on consumers. In addition, a list of potential formats/modes of communications was generated. Overall, traditional health plan information, such as premium amounts and benefit coverage, was the most common type of data included in the consumer materials reviewed. However, approximately one-half of the organizations also used selected survey-based satisfaction measures, as well as statistical performance measures based on administrative data. The printed report card was the most common format encountered; most report cards include a combination of text and graphics. Cost, space limitations, and level of expertise greatly influenced the choice of communication modes. On the whole, the materials developed by case-study organizations have not undergone rigorous evaluations.

Information from this study was included in several articles published in the Fall 1996 issue of the *Health Care Financing Review*, including: Sangl, J.A. and Wolf, L.F. "Role of Consumer Information in Today's Health Care System;," McCormack, L.A., Garfinkel, S.A., Schnaier, J.A., Lee, A.J. and Sangl, J.A., "Consumer Information Development and Use;" and Gibbs, D.A., Sangl, J.A. and Burrus, B. (1996, Fall). "Consumer Perspectives on Information Needs for Plan Choice." The contractor is preparing a final report.

95-057 Beneficiary Information, Education and Marketing Strategy

Project No.:	500-95-0063
Period:	September 1995-September 1997
Funding:	$515,000
Award:	Contract
Principal Investigator:	Lisa Adato
Awardee:	Benova, Inc. 1220 SW Morrison, Suite 700 Portland, OR 97205
HCFA Project Officer:	Leslie M. Greenwald, Ph.D. Office of Strategic Planning

Description: This contract, awarded in 1995 to Benova, Inc., supported the education and third-party enrollment activities envisioned for the planned Medicare Managed Care Competitive Pricing Demonstrations. Specifically, the purposes of this project were to:

- Develop an outreach strategy to reach all beneficiaries in the competitive bidding demonstration market area, and encourage them to take advantage of new opportunities to learn about the Medicare program and its options.
- Develop a strategy for improved/innovative beneficiary education and understanding about health plan options under Medicare.
- Develop specific prototype strategies and materials that will enable beneficiaries to choose effectively

between new and different types of insurance plans in a third-party enrollment process.

The project designed a range of outreach materials (including posters, models for public service announcements, and informational pamphlets) that will be used in the Competitive Pricing demonstration to encourage beneficiaries to participate in new educational opportunities sponsored by HCFA. The project also developed prototype beneficiary handbooks and managed care plan/Medigap plan comparison charts that use alternative formats to simplify information and present it in a beneficiary-friendly way. These education and outreach materials were refined through a beneficiary focus group and cognitive testing program. Finally, the project developed some models for third party enrollment for Medicare managed care.

Status: The project was completed on September 30, 1997. Prototype outreach and third party enrollment strategy descriptions are available, as are prototype Medicare beneficiary educational materials.

95-001 **Evaluation of the Impact of Health Plan Report Cards on Consumer Knowledge, Attitudes, and Choice in a Managed Competition Setting**

Project No.:	18-P-90601/5
Period:	September 1995-December 1996
Funding:	$334,542
Award:	Grant
Principal Investigator:	David J. Knutson
Awardee:	HealthSystem Minnesota 3800 Park Nicollet Boulevard St. Louis Park, MN 55416
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Office of Strategic Planning

Description: The purpose of this study was to determine whether the dissemination of report card information about health care plans to consumers who choose health plans within a managed care competition framework would influence their knowledge of health plan characteristics, attitudes toward health plans, or choice of a health plan. The study population was employees of the State of Minnesota Group Insurance Program, in which employees select health plans during an annual fall open enrollment period. Some members of the program received report cards before they made their 1995 enrollment decisions, and a control group did not. Both groups were surveyed before and after they made their health plan selections. Results assisted policy makers to determine how to shape health plan report cards to best assist consumer decisionmaking.

Status: This project has been completed. Investigators found no report card impact on employees' knowledge of health plans, their attitudes about the quality of health plans, or their choices in selecting a managed health care plan. A number of plan characteristics, such as price, were found to be strongly related to health plan choice. These findings are consistent with other research on determinants of health plan choice by consumers. The investigators suggested that the current versions of heath plan report cards are works in progress and that consumers do not seem to be influenced by the information in any of the ways measured in this study. The final report, "The Impact of Report Cards on Employees: A Natural Experiment," is available from the National Technical Information Service, accession number PB98-103310. A related article, "Employer-Specific Versus Community-Wide Report Cards: Is There a Difference?" by David J. Knutson et al, appeared in the *Health Care Financing Review*, Fall 1996.

97-029 **Evaluation of Customer Service Projects**

Project No.:	500-97-0437
Period:	September 1997-September 1998
Funding:	$169,159
Award:	Contract
Principal Investigator:	Lucy Matsik
Awardee:	Booz Allen and Hamilton, Inc. 8383 Greensboro Drive McLean, VA 22102-3838
HCFA Project Officer:	Elizabeth Goldstein, Ph.D. Center for Beneficiary Services

Description: This project involves a series of evaluations focusing on customer service projects. Current examples of such projects are the Western Consortium Trailblazers and Correspondence Tracking. There are expected to be four types of evaluations: Formative, Process, Outcome and Impact. The specific projects to be evaluated will be designated during the process of the contract as will the type of evaluation.

Status: Currently, the contractor is in the process of designing evaluations for the technical aspects of the Maryland Customer Service Project and for a pilot testing On-Line Call Detail Data/Real Time--a technology for monitoring customer service centers.

96-080 **HCFA On-Line: Market Research for Beneficiaries**

Project No.: 500-95-0057/02

Period: April 1996-December 1997
Funding: $2,865,582
Award: Task Order
Principal Investigator: Kathryn Langwell
Awardee: Barents Group, LLC.
2001 M Street, NW.
Washington, DC 20036
HCFA Project Officer: Thomas W. Reilly, Ph.D.
Center for Beneficiary Services

Description: HCFA has implemented a market research program to provide ongoing assessment of the information needs of our beneficiaries. It will examine what information beneficiaries want and need from HCFA and how such information can best be communicated to them. HCFA is placing special emphasis on understanding the requirements of subgroups who may have special communication needs (e.g., vision-impaired or non-English-speaking beneficiaries). The research consists of multiple phases, including conducting inventories of existing information on communication strategies relevant for beneficiaries, conducting focus groups to explore the information needs of beneficiaries, and collecting and analyzing survey data on information needs in beneficiary populations. This research will be used to help guide the development of HCFA's communication strategy.

Status: Approximately 50 focus groups have been conducted with the general population of Medicare beneficiaries including a number with special groups. Examples of these special groups are those with physician disabilities that interfere with communications, languages other than English, low educational levels and individuals about to enroll in Medicare. An inventory of groups that work with beneficiaries is complete and includes information from approximately 170 organizations. Examples of such groups are advocacy organizations, social service providers, health care providers, government agencies and Medicare carrier and other insurance organizations. In addition, a special supplement to the Medicare Current Beneficiary Survey was used in the fall of 1997 to collect information on the information needs and preferences of beneficiaries. As of the end of December 1997, the analysis of these data was underway.

96-005 Market Research for Providers and Partners

Project No.: 500-95-0057/03
Period: September 1996-September 1998
Funding: $1,091,113
Award: Task Order
Principal Investigator: Kathryn Langwell
Awardee: Barents Group, LLC
2001 M Street, NW
Washington, DC 20036
HCFA Project Officer: Sherry A. Terrell, Ph.D.
Office of Strategic Planning

Description: HCFA market research efforts support the agency's comprehensive communication strategy. Market research is one component of the overall strategy to enhance interaction between HCFA and its customers and partners and to ensure communications are efficient and cost-effective. This particular task order will study systematically the information needs of providers and other partners (POPS). For market research purposes, providers are defined as physicians and hospitals and other partners are defined as State Medicaid programs and managed-care plans, who participate in Medicare programs. For each group, answers to two questions will be sought--what information is needed from HCFA, and how best can the information be provided. The market research methodology will include three basic activities which are to:

- Inventory existing information and communications strategies relevant for POPs.
- Conduct focus groups with members or representatives of these groups.
- Survey POPs for information not available from the first two methods.

POPs' recommendations will be used to inform HCFA's customer communication strategy and to develop innovative service techniques and systems to better meet information needs.

Status: Market research on managed care providers is near completion. Managed care providers believe that HCFA uses some effective communication practices and that for the most part providers are able to obtain most essential information needed for effective operations. However, they have many suggestions about how to improve the process, and reorganize and distribute information for both general provider audiences and more narrowly defined (specialized) audiences. Findings are summarized in the following reports which are available from the National Technical Information Service:

- "HCFA (On-Line): Market Research for Providers -- Final Focus Group Report on the Managed Care Module" (June 1997), accession number PB97-180673.

- "HCFA (On-Line): Market Research for Providers --

Final Inventory Report on the Managed Care Module" (June 1997), accession number PB97-180681.

In the final year of the task order, Barents will analyze information from the *Federal Register*, "A Notice of Request for Comments from Health Maintenance Organizations (ORD-103-GN)," and conduct a survey of physicians. Draft final inventory reports for hospital and physician providers are currently under review. A final report integrating customer recommendations across all provider and other partner groups is expected in September 1998.

96-055 **Evaluation of HCFA On-Line**

Project No.:	500-95-0062/02
Period:	July 1996-September 1997
Funding:	$1,210,311
Award:	Task Order
Principal Investigator:	Gary Gaumer, Ph.D.
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Elizabeth Goldstein, Ph.D. Center for Beneficiary Services

Description: HCFA On-Line is a comprehensive communications strategy designed to enhance the interaction between HCFA and its beneficiaries, providers and other partners. The purpose of this project is to develop evaluation designs to monitor and evaluate under a continuous quality improvement framework the projects included under HCFA On-Line, to provide technical assistance to the bureaus which are conducting the evaluation activities, and to develop outcome measures to evaluate HCFA's progress in improving its overall communications with their beneficiaries, providers, and other partners over time.

Status: The contractor is working with various components in HCFA to design and implement evaluations of their activities. Some of these activities include HCFA's 1-800 telephone services, the managed care comparability chart, training on managed care for Insurance Counseling Agencies, and the HIV/AIDS Consumer Information Project.

IM-030 **Influenza Immunization Initiative**

Funding:	Intramural
HCFA Project Director:	David K. Baugh Office of Strategic Planning

Description: Influenza immunizations are an important measure to prevent morbidity and mortality in our elderly population. In response to the Government Performance and Results Act of 1993, HCFA established a goal of achieving a 59-percent immunization rate among Medicare beneficiaries age 65 or older in fiscal year 1999. In 1996, there was a Medicare paid claim for 43.2 percent of Medicare beneficiaries age 65. This represents an absolute increase from 1994 (3.5 percent) and 1995 (2.2 percent). The rates were 45.5 percent for Caucasians versus 23.4 percent for African Americans. These increases also reflect continued progress toward the Department of Health and Human Services Year 2000 goal of at least a 60-percent influenza immunization rate for all persons age 65 years or older. While immunization rates have increased steadily since Medicare began coverage of this service in 1993, it is unlikely, if the current trend continues, that the goal of 59 percent will be realized in 1999.

Status: For 1996, Medicare influenza immunization rates for the nation, each State and each county have been prepared for all persons age 65 or older and for Caucasians and African Americans. Further detail is available by age and gender within these racial groups. These data are being released for use at the State and local level in the campaign to increase mammography screening levels. The data will be placed on HCFA's Internet home page in the near future and can then be accessed via the address: www.hcfa.gov/stats/stats.htm.

IM-032 **Mammography Utilization Initiative**

Funding:	Intramural
HCFA Project Director:	David K. Baugh Office of Strategic Planning

Description: Mammography is particularly valuable in reducing breast cancer deaths among older women, who experience the highest incidence and mortality from breast cancer. In response to the Government Performance and Results Act of 1993 (GPRA), HCFA established a goal of increasing by 5 percent between 1997 and 1999, the proportion of female Medicare beneficiaries age 65 or older in the United States who receive a screening or diagnostic mammogram within a 2-year period. In the 1995-1996 period, the rates were 42.9 percent for Caucasian women versus 34.3 percent for African American women. While rates for Caucasians have been consistently higher than for African Americans, rates have increased steadily for both races from previous time periods. The absolute percent change observed in these data between the biennial periods of 1992-1993 and 1995-1996 were 4.5 percent, an increase that was slightly less over 3 years, but

comparable to the GPRA goal over 2 years. These increases also reflect continued progress toward the Department of Health and Human Services' Year 2000 goal of increasing mammography every 2 years to at least 60 percent of women in this age group.

Status: Biennial 1995-1996 Medicare mammography service utilization rates for the nation, each State and each county have been prepared for all women, Caucasian women and African American women. Further detail is available by age within these racial groups. These data are being released for use at the State and local level in the campaign to increase mammography screening levels. The data will be placed on HCFA's Internet home page in the near future and can then be accessed via the address: www.hcfa.gov/stats/stats.htm.

IM-033 **Prostate Disease Information Initiative**

Funding:	Intramural
HCFA Project Director:	Maria A. Friedman, D.B.A. Center for Medicaid and State Operations

Description: As part of its consumer information strategy, HCFA has been considering initiatives to help beneficiaries make more informed choices about treatment options for prostate disease. This includes educating beneficiaries and providers about the full range of therapeutic options available for treatment of prostate-related problems. These are common in elderly men, and their treatment costs Medicare millions of dollars annually. Some prostate conditions are cancerous. In fact, prostate cancer is the most common form of cancer among American men. Surgical treatment for prostate cancer is on the rise. Yet, this course is controversial and its effectiveness has been questioned in relation to non-surgical options. Other prostate conditions are benign. Half of all men 60 years of age or over have swelling of the prostate called benign prostatic hyperplasia (BPH). By 80 years of age, one man in four will require treatment for it. However, BPH and some of its treatments have major side effects that significantly affect beneficiaries' quality of life. For example, men with BPH often experience frequent urination or, conversely, difficulty in postponing urination. Surgical treatment of BPH can cause urinary incontinence and impotence. As a result, patients need to have information available to make an informed treatment choice. Providers need to be educated about treatment options and trained to work with consumers to help them better understand available options.

Status: The outreach portions of this initiative have been taken over by HCFA's Health Status Improvement Team, which has the responsibility for HCFA's consumer information initiatives. Research continues in the Office of Strategic Planning to better understand treatment patterns and outcomes.

96-001 **Research Data Assistance Center; Base Contract**

Project No.:	500-96-0023/01
Period:	September 1996-September 1998
Funding:	$453,146
Award:	Contract, Task Order
Principal Investigator:	Marshall McBean, M.D.
Awardee:	University of Minnesota 1100 Washington Avenue, South Minneapolis, MN 55415-1226
HCFA Project Officer:	Alan W. Bradt Office of Strategic Planning

Description: HCFA created the Research Data Assistance Center (ResDAC) to assist new researchers develop familiarity and use of its massive databases for research on Medicare and Medicaid issues. HCFA's ResDAC contract to the University of Minnesota includes a ResDAC consortium with Boston University, Dartmouth College and Georgetown University. The initial contract period is for 1 year with 4 option years. ResDAC will facilitate and expedite the use of HCFA data for research on Medicare and Medicaid by:

- Serving as a focal point for researchers who are interested in pursuing studies on Medicare and Medicaid programs but lack the expertise to access or manipulate HCFA databases.
- Serving as an educational and training center for researchers who have a need to use HCFA data.
- Staffing a team of Medicare and Medicaid experts who are knowledgeable and experienced in both HCFA's data and its program history to assist researchers in understanding the data.
- Improving researcher access to HCFA data by either providing designated data sets or assisting in developing data requests.

This project will focus on outreach initiatives targeted to those unfamiliar with the use of large administrative data files and database training programs that are tailored to specific data applications.

Status: Under this base contract, individual task orders are awarded (see below) to provide funding for selected ResDAC activities.

96-062 Research Data Assistance Center; Core Operations

Project No.:	500-96-0023/01
Period:	September 1996-March 1998
Funding:	$453,146
Award:	Task Order
Principal Investigator:	Marshall McBean, M.D.
Awardee:	University of Minnesota 1100 Washington Ave, South Minneapolis, MN 55415-1226
HCFA Project Officer:	Alan W. Bradt Office of Strategic Planning

Description: HCFA created the Research Data Assistance Center (ResDAC) to assist new researchers to develop familiarity and use of the massive HCFA databases for research on Medicare and Medicaid issues. This ResDAC task provides for the core activities of manning an action desk to take inquiries about the files, the planning of the projects that will be undertaken and the development of sample databases that can be used for training purposes, yet which contains all the attributes (and all the problems) of the originals.

The first task involves five activities:

- Data expertise—ResDAC staff are to enhance their knowledge of the files designated for their use.
- Availability of services—ResDAC staff are to develop an outreach plan to inform researchers of the files, services and training available through ResDAC.
- Research data assistance steering committee—ResDAC staff will participate on the Steering committee.
- Control system—ResDAC staff will develop and test a system to control requests for ResDAC services.
- Charge-back and priority setting system—ResDAC will develop a method to set service priorities for use when resources are limited, and to ensure that data have been paid for before data are released.

Status: The contractor is completing development of outreach materials, particularly a population-based studies training database. In addition, ResDAC is submitting plans for HCFA approval to make presentations at various professional conferences.

97-211 Research Data Assistance Center; Operations Support

Project No.:	500-96-0023/02
Period:	June 1997-March 1998
Funding:	$564,719
Award:	Task Order
Principal Investigator:	Marshall McBean, M.D.
Awardee:	University of Minnesota 1100 Washington Avenue, South Minneapolis, MN 55415-1226
HCFA Project Officer:	Alan W. Bradt Office of Strategic Planning

Description: HCFA created the Research Data Assistance Center (ResDAC) to assist new researchers develop familiarity and use of the massive HCFA databases for research on Medicare and Medicaid issues. This ResDAC task provides operational support, specifically the extension of the action desk service for 3 months and the development of a series of workshops.

Status: Under this task order, the contractor is operating a Researcher Assistance Desk operation, conducting workshops at professional conferences, developing additional training databases, and implementing a researcher training program suitable for graduate level students.

Small Business Innovation Research Grants Program

The Small Business Innovation Development Act of 1982, as amended by Public Law 99-443, requires Federal agencies to reserve a portion of their extramural research and budgets for a Small Business Innovation Research (SBIR) Program. HCFA's SBIR Grants Program is intended to stimulate technological innovation and increase private sector commercialization of innovations derived from Federal research and development. The principal purpose of these grants is to provide assistance to creative applicants so that innovation can be encouraged that will result in an improved health care financing and delivery system.

97-047 **Internet Database for Health Consumers and Purchasers of Care**

Project No.:	97-P-90756/4
Period:	September 1997-September 1998
Funding:	$49,905
Award:	Grant
Principal Investigator:	Cy Rosenblatt
Awardee:	MetroHealth America 4361 N. Honeysuckle Lane Jackson, MS 39211
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: The project would utilize individual provider data components from HCFA's MEDPAR files and the appropriate HCFA databases which would allow any person or organization to determine how one provider compared to another in terms of quality, cost and charges.

Status: This project is in its initial developmental phase.

97-043 **Remote Monitoring of I-131 Therapy Patients**

Project No.:	97-P-90781/3
Period:	September 1997-September 1998
Funding:	$49,999
Award:	Grant
Principal Investigator:	Bryan Boardman
Awardee:	Aware Electronics Corporation PO Box 4299 Wilmington, DE 19807
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This project seeks to develop application software needed to allow an operator to enter patient-specific data and allow monitoring without further intervention of patients who are admitted to hospitals for radioactive Iodine 131 therapy.

Status: This project is in its initial developmental phase.

97-040 **Development of a Resident Assessment Instrument**

Project No.:	97-P-90773/3
Period:	September 1997-September 1998
Funding:	$52,600
Award:	Grant
Principal Investigator:	David Oatway
Awardee:	Chesapeake Applied Technology 9416 Corsica Drive Bethesda, MD 20814
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This is the design and development of a methodology and software to complement the Minimum Data Set and Resident Assessment Instrument. It will bring together a database and methodology to provide tools to document and share clinical knowledge.

Status: This project is in its initial developmental phase.
SBIR

97-045 **Practitioner Office Site Visit Program : The Data Bank System**

Project No.:	97-P-90770/3
Period:	September 1997-September 1998
Funding:	$52,600
Award:	Grant
Principal Investigator:	Judith Willis
Awardee:	CIVS, Inc. 6000 Executive Blvd., Suite 202 Rockville, MD 20852
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This project seeks to develop a data bank system of practitioner office visits that will decrease the number of site visits and thereby decrease the number of interruptions to the practitioner's office and decrease costs to managed care organizations by allowing the managed care organization to access the practitioner site visit information in a centralized data bank.

Status: This project is in its initial developmental phase.

97-032 **Global Fee Distribution Model and Program**

Project No.:	97-P-90759/4
Period:	September 1997-September 1998
Funding:	$50,000
Award:	Grant
Principal Investigator:	Joane Goodroe
Awardee:	Goodroe Administrative Services 750 Hammond Drive, Bldg. 4, Suite 400 Atlanta, GA 30328
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This project will create a model that could be applied to all specialties that accept global pricing. The final product will be software that will enable hospitals and physicians to have measurements to divide the global fees in consideration of changing variables such as global payments, variable costs, quality and other related data.

Status: This project is in its initial developmental phase.
SBIR

97-048 **Detection System to Identify False Medicare Claims Prior to Payment**

Project No.:	97-P-90762/3
Period:	September 1997-September 1998
Funding:	$49,950
Award:	Grant
Principal Investigator:	Robert Smith
Awardee:	Anthem Corporation 12020 Sunrise Valley Drive, Suite 200 Reston, VA 20191
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This project is to evaluate the feasibility of using artificial intelligence software to assist in the identification, investigation and prosecution of health care fraud and abuse related to false claims.

Status: This project is in its initial developmental phase.

97-037 **Software to Assist Medicare Beneficiaries in Comparing Health Maintenance Organizations**

Project No.:	97-P-90749/3
Period:	September 1997-September 1998
Funding:	$53,135
Award:	Grant
Principal Investigator:	Leonard Greenberg
Awardee:	LBD Associates 203 N. Aspen Avenue Sterling, VA 20164
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: The project seeks to develop a software product capable of presenting beneficiaries with structured displays that can be used to compare health maintenance organizations in their area.

Status: This project is in its initial developmental phase.

97-039 **Benchmark Virtual Reality Innovative Procedural Tool**

Project No.:	97-P-90757/3
Period:	September 1997-September 1998
Funding:	$49,781
Award:	Grant
Principal Investigator:	Gregory Merril
Awardee:	HT Medical Systems 6001 Montrose Road, Suite 902 Rockville, MD 20852
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This project builds on the awardee's current development of virtual reality procedural simulation systems. This will involve the identification of quality assurance protocols for the most common invasive medical procedures-vascular access procedures.

Status: This project is in its initial developmental phase.

97-041 **Standardized Medicare/Medicaid Reimbursement for HCPP and other Small Payors**

Project No.:	97-P-90779/2
Period:	September 1997-September 1998
Funding:	$49,684
Award:	Grant
Principal	

Investigator:	Peter Perry
Awardee:	Advanced Management Research 251 New Karaner Road Albany, NY 12205
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This project will develop an Medicare/Medicaid reimbursement process for HCPP that integrates RBRVS pricing methodologies with coding policies that conform to the Coding Initiative.

Status: This project is in its initial developmental phase.

97-042 **Development of an Internet Site Containing Hospital Performance Measurement**

Project No.:	97-P-90788/4
Period:	September 1997-September 1998
Funding:	$50,000
Award:	Grant
Principal Investigator:	Craig Johnson
Awardee:	American Hospital Directory 507 Club Lane Louisville, KY 40207
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: The project will develop an internet-based directory of hospital performance measures that will be available to help individuals and organizations access HCFA public use data.

Status: This project is in its initial developmental phase.
Hospital

97-050 **Practitioner's Guide to Health Services for Women with Physical Disabilities**

Project No.:	97-P-90766/9
Period:	September 1997-September 1998
Funding:	$49,996
Award:	Grant
Principal Investigator:	Linda Tom-Barker
Awardee:	Berkeley Planning 440 Grand Avenue, Suite 500 Oakland, CA 94610
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: The project will design a guide to provide physicians, emergency room personnel, therapists, nurses and other health professionals with the information they need to provide more efficient and effective health care to women with disabilities.

Status: This project is in its initial developmental phase.

97-049 **Consistent Cardiogram**

Project No.:	97-P-90786/1
Period:	September 1997-September 1998
Funding:	$50,000
Award:	Grant
Principal Investigator:	Robin McFee
Awardee:	Boston Cambridge Tech Corporation 12 A Ellis Drive Worcester, MA 01609
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: The project seeks to develop an entirely new standard of care in electrocardiology. This system will include limb electrodes and the essential element of a precordial electrode device that will be patient anatomically specific. It will be quick and easy to set up.

Status: This project is in its initial developmental phase.

97-052 **An Integrated Health Information Management System**

Project No.:	97-P-90776/1
Period:	September 1997-September 1998
Funding:	$50,000
Award:	Grant
Principal Investigator:	Robert Leary
Awardee:	HSS, Inc. 2321 Whitney Avenue Hamden, CT 06418
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: The project describes a strategy for developing an integrated case mix classification and risk adjustment methodology that reflects the current needs of managed care organizations and integrated delivery systems.

Status: This project is in its initial developmental phase.
Case-mix

95-080 **Design of Specialized Protocol Software to Monitor Health Care and Case Management Data**

Project No.:	97-P-08112/8-02

Period: June 1995-December 1997
Funding: $177,640
Award: Grant
Principal Investigator: Jerry H. Kogan
Awardee: CK Computer Consultants
210 North Higgins, Suite 334
Missoula, MT 59802
HCFA Project Officer: Carl Hackerman
Office of Strategic Planning

Description: This project addresses the need to develop products that help all participants in health care to assess and monitor the quality and level of care furnished to patients. Computer software designed to monitor health care data can provide vital assistance to this end.

Status: Phase I (development) has been completed. The project is currently in Phase II (testing and data gathering). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee. Small

97-038 Database Clinical Documentation for Home Health Agencies

Project No.: 97-P-90794/9
Period: September 1997-September 1998
Funding: $50,000
Award: Grant
Principal Investigator: Marilyn Bloom
Awardee: Creative Health Services
1188 Padre Drive, Suite 153
Salinas, CA 93901
HCFA Project Officer: Carl Hackerman
Office of Strategic Planning

Description: The project will develop a paper documentation system that addresses the requirements set forth in the conditions of participation, for the OASIS, the State requirements and by the Joint Commission on the Accreditation of Health Care Facilities.

Status: This project is in its initial developmental phase.

97-036 Speech Input to an ICD-9-CM Coder Grouper

Project No.: 97-P-90768/4
Period: September 1997-September 1998
Funding: $49,616
Award: Grant
Principal Investigator: Frank Hadlock
Awardee: MetaLingual Systems
10 S. Cedar Avenue
Cookeville, TN 38501
HCFA Project Officer: Carl Hackerman
Office of Strategic Planning

Description: The objective of this project is to determine the feasibility of applying current, commercially available, voice recognition products to the task of selecting ICD-9-CM diagnostic and procedure codes using a coder/grouper software package.

Status: This project is in its initial developmental phase.

97-044 Communications Systems for Caregivers

Project No.: 97-P-90750/9
Period: September 1997-September 1998
Funding: $49,990
Award: Grant
Principal Investigator: Eric Brown
Awardee: TechnoView
4500 Campus Drive, Suite 214
Newport Beach, CA 92660
HCFA Project Officer: Carl Hackerman
Office of Strategic Planning

Description: The project is targeted at caregivers to elderly patients living independently. This communication system will assist them with the procedures that they must perform.

Status: This project is in its initial developmental phase.

Dissertation Fellowship Grants Program

Under the Dissertation Fellowship Grants Program, HCFA annually awards grants to a limited number of graduate students completing doctoral dissertations in various social science disciplines investigating health care financing and delivery issues. This grant support is designed to aid the career development of new health services researchers and to encourage individuals to study issues impacting the Medicare and Medicaid programs.

97-010 **Development of a Standardized Donor Ratio**

Project No.:	30-P-90729/5-01
Period:	March 1997-March 1998
Funding:	$21,600
Award:	Grant
Principal Investigator:	Sheryl Lynn Stogis
Awardee:	University of Michigan School of Public Health 109 S. Observatory Ann Arbor, MI 48109
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This study will develop a Standardized Donor Ratio (SDR) to help measure the effectiveness of the Organ Procurement Organizations (OPOs) in the United States. This proposed measure represents an improvement over current measures of the effectiveness for OPOs. The development and application of an SDR can provide information to assess how well OPOs are maximizing organ resources.

Status: In progress.

96-016 **A Longitudinal Study of the Determinants and Outcomes of Drug Utilization by People with HIV Disease**

Project No.:	30-P-90669/5-01
Period:	March 1996-March 1997
Funding:	$21,117
Award:	Grant
Principal Investigator:	Scott Smith
Awardee:	University of Michigan 1028 College of Pharmacy Ann Arbor, MI 48109
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This project is to develop an approach for analyzing variability in drug utilization data. It will use a repeated measures design to analyze data from the AIDS Costs and Services Utilization Survey. The study has four objectives: (1) describe prescription and nonprescription drug utilization patterns in HIV, (2) determine the effect of insurance loss on drug use, (3) establish whether measures of access to medical care are associated with drug utilization, (4) ascertain whether the use of HIV-related prescription drugs affects hospital admissions, and (5) characterize the usefulness of the Andersen Behavioral Model of Health Services Utilization in drug utilization research.

Status: In progress.

97-009 **Assessing Hospital Quality: An Outcome Study of Patients with Acute Myocardial Infarction in Massachusetts Hospitals**

Project No.:	30-P-90739-1-01
Period:	March 1997-March 1998
Funding:	$21,600
Award:	Grant
Principal Investigator:	Mei Wang
Awardee:	University of Massachusetts Public Policy Program 100 Morrissey Boulevard Boston, MA 02125
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This study will examine outcomes of patients with acute myocardial infarction in Massachusetts hospitals. Information from the study could assist HCFA's future quality monitoring and assurance activities.

Status: In progress.

97-008 **Attributing Health Care to Diabetes: The Case of Inpatient Medicare in Texas, 1995**

Project No.:	30-P-90725/6-01
Period:	March 1997-March 1998

Funding: $21,600
Award: Grant
Principal Investigator: Roy McCandless
Awardee: University of Texas School of Public Health
P.O. Box 20036
Houston, TX 77225
HCFA Project Officer: Carl Hackerman
Office of Strategic Planning

Description: This study will compare different methods for estimating health services use and costs associated with diabetes for Medicare beneficiaries in Texas who are not enrolled in health maintenance organizations. Diabetes is a medical condition affecting many Medicare beneficiaries and costs of treating its complications are substantial. The study could provide a better understanding of how different methods of estimation affect national estimates of health care expenditures.

Status: In progress.

96-013 **Kidney Allocation to Patients on the Transplant Waiting Lists--A Comprehensive Study**

Project No.: 30-P-90673/01
Period: March 1996-March 1997
Funding: $20,097
Award: Grant
Principal Investigator: Stefanos Zenios
Awardee: Massachusetts Institute of Technology
14977 Massachusetts Ave., Room E40
Cambridge, MA 02139
HCFA Project Officer: Carl Hackerman
Office of Strategic Planning

Description: There is a shortage of kidneys for transplantation. The allocation process for available organs emphasized expected medical benefit, thus transplantation is different across age groups, genders, and races. This study seeks to provide insights about conditions that contribute to the differences in access to kidneys and to develop an allocation algorithm that is more equitable but does not compromise medical benefit.

Status: In progress.

96-015 **Prior Mammography Use: Does it Explain Black-White Differences in Breast Cancer Outcomes**

Project No.: 30-P-90665/6-01
Period: March 1996-March 1997
Funding: $21,600
Award: Grant
Principal Investigator: Ellen McCarthy
Awardee: Tulane University
1430 Tulane Avenue
New Orleans, LA 70112
HCFA Project Officer: Carl Hackerman
Office of Strategic Planning

Description: African-American women experience poorer breast cancer outcomes than white women. They are more likely to be diagnosed with cancer in an advanced stage and have worse survival rates. The differences may be due to the lower use of screening mammography. This study will use the Linked-Tumor Registry Database created by the National Cancer Institute and HCFA. It contains clinical and medical outcomes and physicians' claims data for women aged 65 and older with breast cancer. It will examine the role of prior mammography as related to differences in breast cancer outcomes.

Status: In progress.

96-019 **Effects of State Medicaid Policies on the Risk of Nursing Home Admission and Length of Stay**

Project No.: 30-P-90675/2-01
Period: March 1996-March 1997
Funding: $21,600
Award: Grant
Principal Investigator: Haruko Nogochi
Awardee: City University of New York
33 West 42nd Street
New York, NY 10036
HCFA Project Officer: Carl Hackerman
Office of Strategic Planning

Description: This study will investigate the influences of both an elderly person's health stock and the variation in Medicaid policies among States on the risk of nursing home entry, discharge, and the hazard of mortality (either in the community or in a nursing home). It will use the national Long-Term Care Survey data. The above risks will be analyzed in a competing risks approach in two periods, 1982-1984 and 1984-1989, separately. Secondly, the researcher will extend the regression form of a semi-parametric hazard model to the model with time-varying covariates, which allows the effect of independent variables that vary over time.

Status: In progress.

96-021 **Organizational Double Agents: Agency and Institutionalism In Medical Group Governance**

Project No.:	30-P-90679/9-01
Period:	March 1996-September 1997
Funding:	$21,311
Award:	Grant
Principal Investigator:	Heather Elms
Awardee:	University of California at Los Angeles 405 Higard Avenue Los Angeles, CA 90095
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This study will examine the determinants of governance structures in U.S. medical groups. Agency theory suggests that these structures will focus on aligning incentives between physicians and their groups and that these arrangements will transfer some risk from contracts with suppliers--namely, health maintenance organizations--to individual providers. Institutional approaches argue that non-efficiency based issues, such as professionalism, may instead cause medical groups to utilize governance structures that protect physicians from financial incentives in medical decision making. The empirical analysis will be based on a survey of compensation, ownership, and monitoring arrangements among medical groups sampled from a comprehensive data base of California medical groups.

Status: In progress.

96-018 **Modeling Case Manager's Care Planning Decisions for Community Dwelling Disabled Elders in Medicaid HCBS Waiver Programs**

Project No.:	30-P-90671/5-01
Period:	March 1996-December 1997
Funding:	$21,600
Award:	Grant
Principal Investigator:	Howard Degenholtz
Awardee:	University of Minnesota 420 Delaware Street Minneapolis, MN 55455
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: Little is known about how consumer preferences affect case managers' care planning decisions. The research will investigate three elements of this interaction (1) the effect of client preferences on case managers' care planning decisions, (2) how the effect of client preferences changes as client functional disability increases and as available resources decrease, and (3) whether client preferences on case manager decisions varies between individual case managers and/or across agencies.

Status: In progress.

97-007 **The Impact of Supplemental Medicare Insurance on Medicare Costs**

Project No.:	30-P-90727/5-01
Period:	March 1997-September 1998
Funding:	$21,460
Award:	Grant
Principal Investigator:	Adam Atherly
Awardee:	University of Minnesota 402 Delaware Street, S.E., Box 729 Minneapolis, MN 55455
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This study will use information from HCFA's Medicare Current Beneficiary Survey data to estimate the effect of supplemental Medicare insurance policies on Medicare costs. This study will be the first to use data collected after insurance industry reforms in 1990. The conclusions of this study will enable policy makers to fully evaluate the role of supplemental insurance in Medicare reform.

Status: In progress.

97-012 **The Impact of Ownership of Dialysis Facilities on Access to Care**

Project No.:	30-P-90730/3-01
Period:	March 1997-March 1998
Funding:	$21,595
Award:	Grant
Principal Investigator:	Wenke Hwang
Awardee:	University of Maryland Baltimore County 1000 Hilltop Circle Baltimore, MD 21250
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This study will examine the patterns of End Stage Renal Disease patients' choices of dialysis facilities and treatments and examine how the type of ownership of these facilities interacts with patients' access by patients' demographic, geographic, and medical

characteristics.

Status: In progress.

97-011 **Subacute Care in Skilled Nursing Facilities as an Adaptive Response to the New Health care Environment**

Project No.:	30-P-90742/3-01
Period:	March 1997-March 1998
Funding:	$20,515
Award:	Grant
Principal Investigator:	Shu-Chuan Jennifer Yeh
Awardee:	Virginia Commonwealth University Sponsored Programs P.O. Box 980568 Richmond, VA 23298
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: This study will use trend analysis to measure the recent growth of subacute care in skilled nursing facilities (SNFs) and will develop hypotheses to explain the level of subacute care provided by these facilities. Results of the analysis will assist policy makers in evaluating the success of SNFs in better integrating acute care and long-term care.

Status: In progress.

96-017 **Functional Diversity in Health Service Provision: Community Mental Health Center Choice**

Project No.:	30-P-90684/5-01
Period:	March 1996-March 1997
Funding:	$21,600
Award:	Grant
Principal Investigator:	Eloine Plaut
Awardee:	University of Chicago 5801 South Ellis Avenue Chicago, IL 60637
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: Care for persons with long term disabilities often requires the local availability of a wide variety of acute and long term care services. However, a breadth of services sufficient to support cost effective choices is often not available on a local basis. This projects asks whether certain factors encourage (or discourage) organization from offering services across an acute - long term care dimension. More specifically the question is, "...to what degree and under what circumstances have health care organizations, which were developed specifically to serve both acute and community based long term care needs, instead evolved into specialized acute or community based long term care providers?" The organization set to be examines is 672 community mental health centers which survived into 1990.

Status: In progress.

96-012 **Do the Elderly Respond Differently Than the Non-Elderly To Price and Quality Information When Choosing Between Health Plans?**

Project No.:	30-P-90670/5-01
Period:	March 1996-December 1997
Funding:	$21,128
Award:	Grant
Principal Investigator:	Dennis Scanlon
Awardee:	University of Michigan 1420 Washington Heights Ann Arbor, MI 48109
HCFA Project Officer:	Carl Hackerman Office of Strategic Planning

Description: Little is know about how the elderly respond to price incentives when choosing primary health insurance coverage. Even less is known about how individuals, and the elderly in particular, respond to published health plan performance measures. This study attempts to use a conditional logit model to estimate the sensitivity of health plan choice to price and performance measures for three categories of persons: (1) active employees, (2) early retirees, and (3) Medicare eligible retirees of a major corporation. This corporation's health plan enrollment data covers approximately 143,000 records from almost every State for each year between 1994 and 1996. Qualitative data from focus groups will complement the statistical analysis.

Status: In progress.

96-020 **An Evaluation of the Connecticut General Assistance Managed Behavioral Health Care Pilot Program**

Project No.:	30-P-90662/1-01
Period:	March 1996-December 1997
Funding:	$21,600
Award:	Grant
Principal Investigator:	Neil Thakur
Awardee:	Yale School of Medicine 60 College Street

New Haven, CT 06520

HCFA Project Officer: Carl Hackerman
Office of Strategic Planning

Description: Since 1994 Connecticut has provided behavioral health care to General Assistance programs in seven cities. The services are provided to these cash assistance recipients through State-run Local Mental Health Authorities. The multisite design of this pilot project will allow the study to examine how specific capitation and utilization management techniques influence behavioral health care among clients with different levels of functioning.

Status: In progress.

Task Order Contracts

To facilitate its award of new research and demonstration projects, HCFA has established several sets of Task Order Contracts that are awarded to several organizations, which then compete for awards of individual projects, i.e., task orders. Task order contracts provide HCFA with increased flexibility in implementing its research agenda. The Office of Strategic Planning maintains four separate sets of task order contracts (focused on: long term care, managed care, maternal and child health, and general research and demonstrations issues) that are used to design and carry out a broad variety of studies related to health care financing, delivery, and quality of care issues.

LONG TERM CARE TASK ORDER CONTRACTS

Period: May 1996-April 1998
HCFA Project Officer: Jackie Wiegman
Office of Strategic Planning

Description: These task order contracts provide for the design, development, and conduct of research and demonstration projects related to long term care. The intent of these projects is to obtain information in a timely manner for program and policy consideration. Each contract has an initial task order (01) for management. The individual substantive tasks awarded under these contracts are included in the research and demonstration projects descriptions ealier in this volume.

Project No.: 500-96-0003 and Task Order #01, Management
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
Principal Investigator: Robert Schmitz, Ph.D.

Project No.: 500-96-0004 and Task Order #01, Management
Awardee: Center for Health Policy Research
1355 S. Colorado Boulevard, Suite 306
Denver, CO 80202
Principal Investigator: Peter Shaughnessy, Ph.D.

Project No.: 500-96-0005 and Task Order #01, Management
Awardee: Lewin-VHI, Inc.
9302 Lee Highway, Suite 500
Fairfax, VA 22031-1214
Principal Investigator: Lisa Maria Alexich

Project No.: 500-96-0006 and Task Order #1, Management
Awardee: The MedStat Group
4401 Connecticut Avenue, NW
Washington, DC 20008
Principal Investigator: Elizabeth Jackson, Ph.D.

Project No.: 500-96-0007 and Task Order #01, Management
Awardee: Michigan Public Health Institute
2465 Woodlake Circle, Suite 140
Okemos, MI 48864
Principal Investigator: William Weissert, Ph.D.

Project No.: 500-96-0008 and Task Order #01, Management
Awardee: University of Minnesota
School of Public Health
Institute for Health Services Research
420 Delaware Street, SE.
Minneapolis, MN 55455
Principal Investigator: Robert Kane, M.D.

Project No.: 500-96-0009 and Task Order #10, Management
Awardee: The Rand Corporation

1700 Main Street
PO Box 2138
Santa Monica, CA 90402-2138

Principal Investigator: Joan Buchanan, Ph.D.

Project No.: 500-96-0010 and Task Order #01, Management

Awardee: Research Triangle Institute
3040 Cornwallis Road
PO Box 12194
Research Triangle Park, NC 27709

Principal Investigator: Charles Phillips, Ph.D.

MATERNAL AND CHILD HEALTH TASK ORDER CONTRACTS

Period: June 1996-May 1998
HCFA Project Officer: Jackie Wiegman
Office of Strategic Planning

Description: These task order contracts provide for the design, development, and conduct of research and demonstration projects related to maternal and child health. The intent of these projects is to obtain information in a timely manner for program and policy consideration. Each contract has an initial task order (01) for management. The individual substantive tasks awarded under these contracts are included in the research and demonstration projects descriptions ealier in this volume.

Project No.: 500-96-0012 and Task Order #01, Management

Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168

Principal Investigator: Carol Irvin, Ph.D.

Project No.: 500-96-0013 and Task Order #01, Management

Awardee: University of Alabama at Birmingham
Lister Hill Center for Health Policy
701 20th Street, South
AB 1170
Birmingham , AL 35294-0111

Principal Investigator: Janet Bronstein, Ph.D.

Project No.: 500-96-0014 and Task Order #01, Management

Awardee: Health Economics Research, Inc.
411 Waverly Oaks Road, Suite 330
Waltham, MA 02154

Principal Investigator: Janet Mitchell, Ph.D.

Project No.: 500-96-0015 and Task Order #01, Management

Awardee: Lewin-VHI, Inc.
9302 Lee Highway, Suite 500
Fairfax, VA 22031-1214

Principal Investigator: Susanna Ginsburg

Project No.: 500-96-0016 and Task Order #01, Management

Awardee: Mathematica Policy Research
600 Maryland Avenue, SW., Suite 550
Washington, DC 20024

Principal Investigator: Embry Howell, Ph.D

Awardee: The Rand Corporation
1333 H Street, NW., Suite 800
Washington, DC 20005-4707

Project No.: 500-96-0017 and Task Order #1, Management

Principal Investigator: Stephen Long, Ph.D.

Awardee: Research Triangle Institute
3040 Cornwallis Road
PO Box 12194
Research Triangle Park, NC 27709

Project No.: 500-96-0018 and Task Order #1, Management

Principal Investigator: Norma Gavin, Ph.D.

MANAGED CARE TASK ORDER CONTRACTS

Period: September 1995-September 1998
HCFA Project Officer: Jackie Wiegman
Office of Strategic Planning

Description: These task order contracts provide for the design, development, and conduct of research and demonstration projects related to managed care. The intent of these projects is to obtain information in a timely manner for program and policy consideration. Each contract has an initial task order (01) for management. The individual substantive tasks awarded under these contracts are included in the research and demonstration projects descriptions ealier in this volume.

Project No.: 500-95-0046 and Task Order #01, Management
Awardee: Barents Group, LLC.
2001 M Street, NW.
Washington, DC 20036
Principal Investigator: Kathyrn Langwell

Project No.: 500-95-0047 and Task Order #1, Management
Awardee: Mathematica Policy Research, Inc.
PO Box 2393
Princeton, NJ 08543
Principal Investigator: Randall Brown, Ph.D.

Project No.: 500-95-0048 and Task Order #01, Management
Awardee: Health Economics Research, Inc.
411 Waverly Oaks Road, Suite 300
Waltham, MA 02154
Principal Investigator: Janet Mitchell, Ph.D.

Project No.: 500-95-0049 and Task Order #01, Management
Awardee: Lewin-VHI, Inc.
9302 Lee Highway, Suite 500
Fairfax, VA 22031-1214
Principal Investigator: David Stapleton, Ph.D.

Project No.: 500-95-0050 and Task Order #01, Management
Awardee: The MedStat Group
4401 Connecticut Avenue, NW.
Washington, DC 20008
Principal Investigator: William Marder

Project No.: 500-95-0052 and Task Order #01, Management
Awardee: Brandeis University
PO Box 9110
Waltham, MA 02254-9110
Principal Investigator: Joel Cohen

Project No.: 500-95-0053 and Task Order #01, Management
Awardee: University of Minnesota
School of Public Health
Institute for Health Services Research
420 Delaware Street, SE.
Minneapolis, MN 55455
Principal Investigator: Jon Christensen, Ph.D.

Project No.: 500-95-0064 and Task Order #01, Management
Awardee: The Rand Corporation
1700 Main Street
PO Box 2138
Santa Monica, CA 90402-2138
Principal Investigator: Jose Escarce, M.D.

RESEARCH AND DEMONSTRATIONS TASK ORDER CONTRACTS

Period: September 1995-September 1998
HCFA Project Officer: Jackie Wiegman
Office of Strategic Planning

Description: These task order contracts provide for the design, development, and conduct of other research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration. Each contract has an initial task order (01) for management. The individual substantive tasks awarded under these contracts are included in the research and demonstration projects descriptions ealier in this volume.

Project No.: 500-95-0055 and Task Order #01, Management
Awardee: Urban Institute
2100 M Street, NW.
Washington, DC 20037
Principal Investigator: Stephen Zuckerman, Ph.D.

Project No.: 500-95-0056 and Task Order #01, Management
Awardee: The Rand Corporation
1700 Main Street
PO Box 2138
Santa Monica, CA 90402-2138
Principal Investigator: Jose Escarce, M.D.

Project No.: 500-95-0057 and Task Order #01, Management
Awardee: Barents Group, LLC
2001 M Street, NW.
Washington, DC 20036
Principal Investigator: Kathryn Langwell

Project No.: 500-95-0058 and Task Order #01, Management
Awardee: Health Economics Research
411 Waverly Oaks Road, Suite 330
Waltham, MA 02154
Principal Investigator: Janet Mitchell, Ph.D.

Project No.: 500-95-0059 and Task Order #01, Management
Awardee: Lewin-VHI, Inc.
9302 Lee Highway, Suite 500
Fairfax, VA 22031-1214
Principal Investigator: Allen Dobson, Ph.D.

Project No.: 500-95-0060 and Task Order #01, Management
Awardee: Brandeis University
PO Box 9110
Waltham, MA 02254-9110
Principal Investigator: Stanley Wallack, Ph.D.

Project No.: 500-95-0061 and Task Order #01, Management
Awardee: University of Wisconsin
610 Walnut Street
Room 1163, WARF
Madison, WI 53705
Principal Investigator: David Zimmerman, Ph.D.

Project No.: 500-95-0062 and Task Order #01, Management
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
Principal Investigator: Catherine Joseph

MASTER CONTRACTS AND RESEARCH CENTERS

Description: These master contracts provide for the design, development, conduct, and evaluation of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration. Each contractor has a task order (01) for management. The window for new awards under these contracts has passed. Tasks previously awarded are being completed. The activities that would have been awarded under Master Contracts is now being done under the Task Order Contracts (above). The individual substantive tasks appear in their subject areas.

Project:	500-92-0011 and Task Order #01, Management
Awardee:	Mathematica Policy Research, Inc. PO Box 2393 Princeton, NJ 08543
Principal Investigator:	Randall Brown , Ph.D.

Project No.:	500-92-0021 and Task Order #01, Management
Awardee:	Lewin-VHI, Inc. 9302 Lee Highway, Suite 500 Fairfax, VA 22031-1214
Principal Investigator:	Allen Dobson, Ph.D.

Project No.:	500-92-0023 and Task Order #01, Management
Awardee:	The Rand Corporation 1700 Main Street PO Box 2138 Santa Monica, CA 90402-2138
Principal Investigator:	Grace Carter

Project No.:	500-92-0033 and Task Order #01, Management
Awardee:	Research Triangle Institute 3040 Cornwallis Road PO Box 12194 Research Triangle Park, NC 27709
Principal Investigator:	James S. Lubalin

Project No.:	500-92-0035 and Task Order #01, Management
Awardee:	SysteMetrics, Inc. (Santa Barbara, CA)
Principal Investigator:	Marilyn Rymer Ellwood

Topical Index

Alphabetical Index of Research and Demonstration Projects

Index of Awardee Organizations

Index of Principal Investigators

State Index of Research and Demonstration Projects

HCFA Project Officers and Project Directors

To contact the project officers and project directors at the Health Care Financing Administration's Baltimore headquarters, it is best to use telephone or e-mail. Correspondence should be addressed as follows: (Name of project officer or project director), Health Care Financing Administration, (Name of Center or Office), Baltimore, Maryland 21244-1850. Headquarters staff will be moving to new work locations in 1998; thus, it is not possible to cite a specific mail stop.

A

Alisa Adamo
410-786-6618
aadamo@hcfa.gov
Center for Medicaid and State Operations

Sharon Arnold
410-786-0291
sarnold@hcfa.gov
Center for Health Plans and Providers

B

Dan Babish
410-786-6607
dbabish@hcfa.gov
Office of Strategic Planning

Jay Bae, Ph.D.
410-786-6591
jbae@hcfa.gov
Office of Strategic Planning

David K. Baugh
410-786-7716
dbaugh@hcfa.gov
Office of Strategic Planning

M. Beth Benedict, Dr.P.H.
410-786-7724
bbenedict@hcfa.gov
Office of Strategic Planning

Paul J. Boben, Ph.D.
410-786-6629
pboben@hcfa.gov
Office of Strategic Planning

Maria Boulmetis
410-786-0552
mboulmetis@hcfa.gov
Center for Medicaid and State Operations

B *continued*

Brad Braden
410-786-7937
bbraden@hcfa.gov
Office of the Actuary

Alan W. Bradt
410-786-6543
abradt@hcfa.gov
Office of Strategic Planning

Richard Bragg
410-786-7250
rbragg@hcfa.gov
Office of Strategic Planning

Linda Brown
202-690-8172
lbrown1@hcfa.gov
Center for Medicaid and State Operations

Samuel L. Brown, Ph.D.
410-786-6667
sbrown3@hcfa.gov
Office of the Chief of Operations

William Buczko, Ph.D.
410-786-6593
wbuczko@hcfa.gov
Office of Strategic Planning

Sally Burner
410-786-5999
sburner@hcfa.gov
Office of the Actuary

C

Carlos Cano
202-690-7941
ccano@hcfa.gov
Office of Strategic Planning

Peggy Clark
410-786-5321
pclark@hcfa.gov
Center for Medicaid and State Operations

C *continued*

William D. Clark
410-786-1484
wclark1@hcfa.gov
Office of Strategic Planning

Gina P. Clemons
410-786-9644
gclemons@hcfa.gov
Center for Medicaid and State Operations

James Coan
410-786-9168
jcoan@hcfa.gov
Center for Beneficiary Services

Elizabeth S. Cornelius
(Retired; for questions contact Sherwood below)

Philip G. Cotterill, Ph.D.
410-786-6598
pcotterill@hcfa.gov
Office of Strategic Planning

Cathy Cowan
410-786-4880
ccowan@hcfa.gov
Office of the Actuary

Joseph M. Cramer
410-786-6676
jcramer@hcfa.gov
Center for Health Plans and Providers

D

William Damrosch
410-786-6678
wdamrosch@hcfa.gov
Center for Health Plans and Providers

Marsha G. Davenport, M.D.
410-786-6693
mdavenport@hcfa.gov
Office of Strategic Planning

D *continued*
Feather Ann Davis, Ph.D.
(Retired; for questions see Eggers below)

Ronald W. Deacon, Ph.D.
410-786-6622
rdeacon@hcfa.gov
Center for Health Plans and Providers

Teresa L. DeCaro
410-786-6604
tdecaro@hcfa.gov
Center for Health Plans and Providers

Benson L. Dutton
410-786-6603
bdutton@hcfa.gov
Office of Strategic Planning

Spike Duzor
410-786-1794
sduzor@hcfa.gov
Office of Strategic Planning

E
Bonnie M. Edington
410-786-6617
bedington@hcfa.gov
Office of Clinical Standards and Quality

Paul W. Eggers, Ph.D.
410-786-6691
peggers@hcfa.gov
Office of Strategic Planning

William L. England, Ph.D., J.D.
410-786-0542
wengland@hcfa.gov
Office of Clinical Standards and Quality

Frank Eppig
410-786-7950
feppig@hcfa.gov
Office of Strategic Planning

Dan Ermann
202-690-5456
dermann@hcfa.gov
Office of Legislation

F
Jane Forman
410-786-0484
jforman@hcfa.gov
Center for Medicaid and State Operations

Mark S. Freeland
410-786-7952
mfreeland@hcfa.gov
Office of the Actuary

Sherrie L. Fried
410-786-6619
sfried@hcfa.gov
Center for Medicaid and State Operations

Maria A. Friedman
410-786-9915
mfriedman@hcfa.gov
Center for Medicaid and State Operations

G
Sydney Galloway
410-786-6645
sgalloway@hcfa.gov
Office of Strategic Planning

Nancy Goetschius
410-786-0707
ngoetschius@hcfa.gov
Center for Medicaid and State Operations

Elizabeth Goldstein, Ph.D.
410-786-6665
emauser@hcfa.gov (or egoldstein@hcfa.gov)
Center for Beneficiary Services

Kathleen Gondek, Ph.D.
(Moved; for questions see Bae above)

Brigid Goody, Sc.D
410-786-6640
bgoody@hcfa.gov
Office of Strategic Planning

Leslie M. Greenwald, Ph.D.
410-786-6502
lgreenwald@hcfa.gov
Office of Strategic Planning

G *continued*
Joel W. Greer, Ph.D.
410-786-6695
jgreer3@hcfa.gov
Office of Strategic Planning

H
Carl Hackerman
410-786-6644
chackerman@hcfa.gov
Office of Strategic Planning

James P. Hadley
410-786-6626
jhadley@hcfa.gov
Office of Strategic Planning

Rosemarie Hakim, Ph.D.
410-786-6698
rhakim@hcfa.gov
Office of Strategic Planning

Rose M. Hatten
410-786-6630
rhatten@hcfa.gov
Center for Medicaid and State Operations

Stephen Heffler
410-786-1211
sheffler@hcfa.gov
Office of the Actuary

Michael Henesch
410-786-6685
mhenesch@hcfa.gov
Center for Health Plans and Providers

Jeffrey Hinson
410-786-6977
jhinson@hcfa.gov
Center for Health Plans and Providers

Melissa Hulbert, M.P.S.
410-786-8494
mhulbert@hcfa.gov
Office of Strategic Planning

Edward T. Hutton
410-786-6616
ehutton@hcfa.gov
Center for Medicaid and State Operations

I

Melvin J. Ingber, Ph.D.
410-786-1913
mingber@hcfa.gov
Office of Strategic Planning

J

Bruce R. Johnson
410-786-0615
bjohnson2@hcfa.gov
Center for Medicaid and State Operations

K

Michael Kendix, Ph.D.
410-786-6631
mkendix@hcfa.gov
Office of Strategic Planning

Mark A. Krause, Ph.D.
410-786-6683
mkrause@hcfa.gov
Office of Strategic Planning

Lawrence E. Kucken
410-786-6694
lkucken@hcfa.gov
Office of Clinical Standards and Quality

L

Ronald W. Lambert
410-786-6624
rlambert@hcfa.gov
Center for Health Plans and Providers

Lawrence LaVoie
816-426-5039
llavoie@hcfa.gov
Kansas City Regional Office

Katharine Levit
410-786-7942
klevit@hcfa.gov
Office of the Actuary

Jesse M. Levy, Ph.D.
410-786-6600
jlevy@hcfa.gov
Office of Strategic Planning

Kay Lewandowski
410-786-6657
klewandowski@hcfa.gov
Office of Strategic Planning

L *continued*

James D. Lubitz
410-786-6696
jlubitz@hcfa.gov
Office of Strategic Planning

M

Patricia MacTaggart
410-786-1285
pmactaggart@hcfa.gov
Center for Medicaid and State Operations

Leslie A. Mangels
410-786-0494
lmangels@hcfa.gov
Office of Internal Customer Support

Cynthia K. Mason
410-786-6680
cmason1@hcfa.gov
Center for Health Plans and Providers

Siddhartha Mazumdar, Ph.D.
410-786-6673
smazumdar@hcfa.gov
Center for Health Plans and Providers

Dan McCarthy
410-786-2079
dmccarthy@hcfa.gov
Center for Medicaid and State Operations

Pat McDonnell
410-786-7944
pmcdonnell@hcfa.gov
Office of the Actuary

Karen McVearry
410-786-4643
kmcvearry@hcfa.gov
Office of Clinical Standards and Quality

Victor G. McVicker
410-786-6681
vmcvicker@hcfa.gov
Center for Health Plans and Providers

M *continued*

Ann Meadow, Sc.D.
410-786-6602
ameadow@hcfa.gov
Office of Strategic Planning

Renee Mentnech
410-786-6692
rmentnech@hcfa.gov
Office of Strategic Planning

Nancy Miller
410-786-6648
nmiller2@hcfa.gov
Office of Strategic Planning

Stefan N. Miller
410-786-6656
smiller1@hcfa.gov
Center for Health Plans and Providers

N

Phyllis A. Nagy
410-786-6646
pnagy@hcfa.gov
Center for Medicaid and State Operations

Edward Norwood
410-786-6571
enorwood@hcfa.gov
Office of Financial Management

Dennis M. Nugent
410-786-6663
dnugent@hcfa.gov
Office of Strategic Planning

P

Edgar A. Peden, Ph.D.
410-786-6594
epeden@hcfa.gov
Office of Strategic Planning

Joan Peterson, Ph.D.
410-786-0621
jpeterson@hcfa.gov
Center for Medicaid and State Operations

John Phelps
410-786-7939
jphelps@hcfa.gov
Office of the Actuary

P *continued*
Penelope L. Pine
410-786-7718
ppine@hcfa.gov
Office of Strategic Planning

Lia Prela
206-615-2310
cprela@hcfa.gov
Seattle Regional Office

R
Thomas W. Reilly, Ph.D.
410-786-2196
treilly2@hcfa.gov
Center for Beneficiary Services

Gerald F. Riley
410-786-6699
griley@hcfa.gov
Office of Strategic Planning

Carolyn Rimes
410-786-6620
crimes@hcfa.gov
Center for Health Plans and Providers

Suzanne Rotwein, Ph.D.
410-786-6621
srotwein@hcfa.gov
Center for Beneficiary Services

S
Theresa Sachs
410-786-0307
tsachs@hcfa.gov
Center for Medicaid and State Operations

Judith A. Sangl, Sc.D.
(Moved; for questions see Eggers above)

Mary Lee Seifert
410-786-0030
mseifert@hcfa.gov
Office of the Actuary

J. Donald Sherwood
410-786-6651
jsherwood@hcfa.gov
Center for Medicaid and State Operations

S *continued*
Cynthia Shirk
410-786-6614
cshirk@hcfa.gov
Center for Medicaid and State Operations

Herbert A. Silverman
410-786-7702
hsilverman@hcfa.gov
Center for Health Plans and Providers

Gloria J. Smiddy
410-786-7723
gsmiddy@hcfa.gov
Center for Medicaid and State Operations

William J. Sobaski
410-786-6588
wsobaski@hcfa.gov
Office of Strategic Planning

Amy Sobehrad
410-786-5936
asobehrad@hcfa.gov
Center for Medicaid and State Operations

Jean Stiller
410-786-0708
jstiller@hcfa.gov
Office of the Actuary

T
Don Tabor
410-786-7272
dtabor@hcfa.gov
Center for Medicaid and State Operations

Lori Teichman, Ph.D
410-786-6684
lteichman@hcfa.gov
Center for Beneficiary Services

Sherry A. Terrell, Ph.D.
410-786-6601
sterrell@hcfa.gov
Office of Strategic Planning

T *continued*
Thomas Theis
410-786-6654
ttheis@hcfa.gov
Center for Health Plans and Providers

Armen H. Thoumaian, Ph.D.
410-786-6672
athoumaian@hcfa.gov
Office of Clinical Standards and Quality

Anne E. Trontell, M.D.
(Moved; for questions see Davenport above)

Cynthia G. Tudor, Ph.D.
410-786-6499
ctudor@hcfa.gov
Center for Health Plans and Providers

V
Deborah C. Van Hoven
410-786-6625
dvanhoven@hcfa.gov
Center for Medicaid and State Operations

Noemi Villafranca
410-786-6662
nvillafranca@hcfa.gov
Office of Strategic Planning

W
Joan Warren, Ph.D.
(Moved; for questions see Eggers above)

Jackie Wiegman
410-786-6637
jwiegman@hcfa.gov
Office of Strategic Planning

Mark Wynn
410-786-6583
mwynn@hcfa.gov
Center for Health Plans and Providers

HCFA RESEARCH: CHANGING HEALTH CARE FINANCING AND DELIVERY

Over the past three decades, HCFA's research and demonstrations program has had a profound impact on the evolution of the Medicare and Medicaid programs. Through support, development, and testing of innovations in payment, delivery, access and quality, HCFA has significantly contributed to major program reforms and improvements. The following accomplishments are just a few of the major contributions of this research program.

INNOVATIVE PAYMENT METHODS

Hospitals. With HCFA-supported research and demonstrations, Medicare moved from cost reimbursement for inpatient hospital care to a prospectively determined per case payment based on diagnosis. HCFA's efforts resulted in legislation requiring the use of a DRG system—diagnosis-related groups—as the method of Medicare payment for most hospital care. Implemented in 1983, the DRG system saves billions of Medicare dollars annually and is used today by half of the state Medicaid programs, CHAMPUS, and many insurers, managed care plans, and other countries. It represents the most common form of hospital payment in the U.S. today.

Physicians. Through HCFA-supported research, a uniform, resource-based fee schedule for paying physicians was developed to replace Medicare's previous retrospective, charge-based system. This new system was part of physician payment reform legislated in 1989 and implemented in 1992. The concept of using resource-based payment for physician services has spread beyond Medicare to nearly three-quarters of public and private insurers.

Managed Care. Medicare currently pays HMOs a capitated amount for each enrollee based on average fee-for-service spending in the enrollee's demo-graphic group. HCFA's research studies showed that HMO enrollees tend to be healthier than average, indicating that capitation amounts may be too high. HCFA has taken the lead in pursuing all viable methods of developing risk adjustment methodologies, such as ambulatory care groups (ACGs) and diagnostic cost groups (DCGs), which use diagnoses from a prior year to predict program costs in a subsequent year. HCFA also is exploring the development of other risk adjustment mechanisms, including ACG- and DCG-hybrids, and adjusters for various populations such as the under-65 group and the disabled.

Nursing Homes. An innovative payment classification system developed through HCFA research has the potential for significantly changing payment in various care settings. Resource Utilization Groups (RUGs) classify patients based on costs according to the relationship of their various medical, functional, and personal characteristics and their daily use of staff time. RUGs originally were developed for reimbursement of care received by Medicaid residents in nursing homes. More recently, the concept was adapted and refined for paying for Medicare-covered patient care in certified skilled nursing facilities. A six-state HCFA demonstration project is underway to pay nursing homes for Medicare and Medicaid patients on a prospective basis tied largely to residents' needs. The Balanced Budget Act of 1997 establishes a national prospective payment system for Medicare skilled nursing facilities based on the experience of HCFA's research and demonstrations.

Home Health Agencies. HCFA has implemented a demonstration of per-episode prospective payment system for Medicare home health services and is collecting extensive data on the characteristics of Medicare beneficiaries who experience an episode of home health care. This information will be used to develop a case-mix adjustor to assure that payment is appropriate to the service needs of patients. These initiatives will be used to shape a national prospective payment system for Medicare home health care mandated by the Balanced Budget Act.

Centers of Excellence. HCFA has successfully developed and demonstrated negotiated package prices for all services during episodes of high-cost/high volume surgeries (heart bypass and cataract), aimed at reducing spending by the program and its beneficiaries and providing high quality services.

Outpatient Services. Hospital outpatient departments are currently paid by Medicare on a cost basis. The Balanced Budget Act requires Medicare to establish a prospective system for outpatient services. Ambulatory Patient Groups (APGs), developed by HCFA-sponsored research, have made prospective payment for these services possible.

NEW HEALTH CARE DELIVERY SYSTEMS

Hospice. When the hospice movement was still in its infancy, HCFA initiated a Medicare/Medicaid demonstration to determine whether hospice care could maximize patient autonomy during the last weeks of life and allow terminally ill patients to die with as much dignity as possible and relatively free of pain. Largely as a result of this successful demonstration effort, legislation established hospices as authorized Medicare providers. In 1995, about 300,000 Medicare beneficiaries used hospice care.

Swing-Beds. In the 1970s, the shortage of nursing home beds for frail elderly in many rural areas along with excess hospital bed capacity in those areas led HCFA to test the swing-bed concept—the use of existing hospital staff and facilities to render both acute and long-term care. The successful demonstrations resulted in legislation authorizing the rural swing-bed program for small rural hospitals.

Home and Community-based Care. Beginning in the mid-1970s, HCFA sponsored a series of innovative Medicare and Medicaid demonstrations throughout the country to test the use of community-based services as substitutes for more costly institutional care. These demonstrations served as the framework for legislation authorizing the Medicaid 1915(b) waiver program in which home and community-based services may be covered services.

HMO Participation. Originally, Medicare was essentially a fee-for-service program, with limited enrollment in the incentive-payment HMOs authorized under section 1876 of the Social Security Act. Through an extensive demonstration effort, HCFA tested the use of capitation for HMOs participating in Medicare. This pioneering effort demonstrated to plans, Congress, and the executive branch that HMO participation in Medicare on a capitated basis was a viable option.

Program for All-Inclusive Care for the Elderly (PACE). The PACE demonstration replicated a unique model of managed care service delivery for very frail community-dwelling elderly, most of whom are dually-eligible for Medicare and Medicaid and all of whom are assessed as being eligible for nursing home placement according to the standards established by the participating States. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. The Balanced Budget Act of 1997 has established PACE as a permanent part of the Medicaid program and as a State option under Medicaid.

State Medicaid Demonstrations. Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad discretion to waive certain laws pertaining to Medicaid, in order to conduct experimental, pilot or demonstration projects. This authority allows states and the federal government to pursue Medicaid projects that test new and innovative ideas relating to benefits and services, eligibility requirements and processes, program payment, and service delivery. These demonstrations are frequently aimed at serving more low-income and uninsured people while reducing expenditures through new program efficiencies.

Since January 1993, HCFA has approved 18 comprehensive health care reform demonstration projects, and the framework of one additional demonstration. In addition, 19 states have received Medicaid waivers since January 1993, as part of larger welfare reform projects. These complementary Medicaid waivers enable states to continue providing essential health care services while encouraging independence from welfare. Finally, 25 sub-state Medicaid demonstration projects have been approved, affecting smaller components of state Medicaid programs.

IMPROVING ACCESS AND QUALITY

Access Measurement. HCFA pioneered methods of measuring access to care for vulnerable populations. Using these methods, HCFA has produced numerous studies documenting potential access problems among such vulnerable subgroups as racial minorities, the disabled, low-income and persons with AIDSs. These studies were among the first to document significant racial differences in access to care by Medicare beneficiaries and resulted in a variety of initiatives to address the differentials.

Nursing-Home Quality of Care Measurement. HCFA-sponsored research has developed outcome-oriented quality-of-care indicators for nursing homes. The result is an outcome-based quality improvement system and a set of quality-of-care indicators developed using resident-level assessment information.

FACTS ABOUT THE HEALTH CARE FINANCING ADMINISTRATION

The Health Care Financing Administration (HCFA) was created on March 9, 1977 to consolidate in one agency the responsibility for administering the largest federal health programs, Medicare and Medicaid.

In fiscal year 1996, HCFA spent an estimated $359.4 billion to finance health care services to elderly, disabled and poor Americans in the Medicare and Medicaid programs. The expenditures include administrative costs, which are less than three percent of HCFA's annual budget.

The agency has approximately 4,000 employees engaged in policy development, program operations, legislative analysis and liaison activities, health care research and demonstrations, budget preparation and analysis, actuarial studies, data collection and processing, enforcement of health care quality standards, and public information activities.

MEDICARE

Medicare provides health insurance coverage for people 65 and over, younger people who are receiving Social Security disability benefits, and persons who need dialysis or kidney transplants for treatment of end-stage kidney disease.

Medicare in fiscal year 1996 provided health care coverage for more than 38 million people at a cost estimated at $196.6 billion. The beneficiaries included approximately 33 million aged, five million Social Security disability enrollees, and 270,000 end-stage kidney disease patients.

More than 4.9 million Medicare beneficiaries are enrolled in managed-care plans such as HMOs that provide them with all Medicare-covered services.

MEDICAID

Medicaid, which provides health care coverage for the poor, is administered by the states with matching funds from the federal government. Federal law mandates coverage of basic health care services for categories of low-income people. States have the option of covering other needy people and providing medical services not mandated by federal law.

The federal-state Medicaid program covered nearly 37 million people in fiscal year 1996 at an estimated cost of $163 billion, of which the federal share was estimated at $92 billion.

Successful managed care programs provide medical services for 13 million Medicaid beneficiaries through Medicaid managed care or statewide waivers in 41 states.

HEALTH STANDARDS AND QUALITY

HCFA is responsible for implementing federal quality assurance standards in 157,000 laboratories, 17,400 nursing homes, 6,300 hospitals, and nearly 10,000 home health agencies as well as more than 12,500 ambulatory surgical centers, hospices and 25,000 other facilities.

State inspection teams working under agreement with HCFA conduct surveys of health care providers and suppliers to ensure compliance with federal standards for health, safety and quality of care. Follow-up inspections are performed when necessary to bring facilities into compliance. Approximately 5,700 state surveyors perform the inspections, and their work is monitored by approximately 100 HCFA surveyors.

Peer Review Organizations in every state operate under contracts with HCFA to ensure that the medical services provided to Medicare patients in hospitals and certain outpatient settings are medically necessary, appropriate and meet acceptable quality standards.

INSURANCE REGULATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. HIPAA has separate provisions for the large and small group health insurance markets, and the individual market. HCFA and the Department of Health and Human Services work in coordination with the Departments of Labor and Treasury to administer these HIPAA provisions.

Health Care Financing Review

A New Agenda

A New Century

The *Health Care Financing Review* is your source for up-to-date and comprehensive health care financing information. Throughout the major changes taking place in the public and private health care sectors, the *Review* has stayed on the cutting edge of research and policy. In the past year, thematic issues of the *Review* have covered such headline topics as health care quality, State health reform, and rural health. The *Review* has given broad coverage to such issues as the managed-care revolution and innovative State Medicaid waiver programs, while maintaining a balance between government and private-sector contributors, researchers, and front-line policy-makers.

The *Review* continues to provide you with the information you need—from the *Annual Statistical Supplement* and summaries of legislative changes to conference, publication, and policy announcements. We also look toward the next century with national health expenditure projections. And our thorough national coverage is paired with important State-level research and analysis.

The *Health Care Financing Review* is your most important resource for understanding the financial challenges facing health care today and predicting the trends shaping tomorrow.

Clip Here

Superintendent of Documents **Subscriptions** Order Form

Charge your order
It's Easy!

MasterCard VISA

Order Processing Code: 7766

To FAX your orders: (202) 512-2250

☐ YES, enter my subscription(s) as follows:

_____ subscription(s) of the ***Health Care Financing Review*** for $30 per year.

The total cost of my order is $_____. International customers please add 25%. Prices include regular domestic postage and handling and are subject to change.

_____
(Company or Personal Name) (Please type or print)

_____
(Additional address/attention line)

_____
(Street address)

_____
(City, State, ZIP Code)

_____
(Daytime phone, including area code)

_____
(Purchase Order No.)

May we make your name and address available to other mailers? YES ☐ NO ☐

Please Choose Method of Payment:

☐ Check payable to the Superintendent of Documents

☐ GPO Deposit Account ☐☐☐☐☐☐ - ☐

☐ Visa or MasterCard Account

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐ (Credit card expiration date) Thank you for your order!

_____
(Authorizing signature) 12/93

Mail To: New Orders, Superintendent of Documents
P.O. Box 371954, Pittsburgh, PA 15250-7954

Availability of Project Reports and Results

As extramural research projects sponsored by the Health Care Financing Administration (HCFA) are completed, the final reports are placed with the National Technical Information Service (NTIS) for public access. For these reports, the NTIS accession number is included in the project writeup for ordering purposes. Furthering information may be obtained from: National Technical Information Service, Document Sales, 5285 Port Royal Road, Springfield, Virginia 22161, (703) 487-4650. Information about NTIS reports is available on the Internet at http://www.fedworld.gov.

A few final reports are published by HCFA as part of its extramural report series. These reports are available for purchase from the U.S. Government Printing Office (GPO). Reports must be ordered by title and stock number directly from GPO. Again, the stock number of a published final report is included in the project writeup. These reports may be ordered by sending a check or money order to: Superintendent of Documents, P.O. Box 371954, Pittsburgh, Pennsylvania, 15250. Information about GPO reports is available on the Internet at http://www.access.gpo.gov.

A list of research reports produced by HCFA, and their NTIS accession numbers and GPO stock numbers, may be viewed on HCFA's Internet home page at http://www.hcfa.gov.

U.S. Department of
Health and Human Services
Health Care Financing Administration
Office of Strategic Planning
7500 Security Boulevard
Baltimore, Maryland 21244-1850

HCFA Pub. No. 03405
March 1998